

**Commonwealth of Massachusetts**

**Executive Office of Elder Affairs**

# **State Plan on Aging 2014-2017**

**Deval Patrick**

*Governor*

**Ann L. Hartstein**

*Secretary*

**October 2013**



*The Commonwealth of Massachusetts*  
*Executive Office of Elder Affairs*  
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Dear Friends and Colleagues:

The Executive Office of Elder Affairs is pleased to present the Massachusetts State Plan on Aging ("the Plan") for Federal Fiscal Years 2014 through 2017. The Plan serves as the structure for shaping the policy development and programs Elder Affairs will pursue to advance its vision: to empower individuals to make their own choices based upon their preferences and desires and to encourage individuals to make a plan for achieving and sustaining quality of life goals, including aging in place with dignity, financial well-being and healthy aging.

Elder Affairs is the designated State Unit on Aging, and as administrator of the plan, provides insight into programs, services and opportunities to support a comprehensive and coordinated system for serving elders and their caregivers in the Commonwealth. In aligning an agenda that builds greater capacity for home and community-based services, the Plan addresses Elder Affairs' role as the primary advocate and spokesman in the Commonwealth on behalf of older individuals and their caregivers. The Plan provides a description of the services available to aging adults through the Older Americans' Act, Medicaid and state-funded programs.

The Plan also illustrates Massachusetts' commitment to its "Aging Agenda". Capturing nine principles for aging well, the Aging Agenda recognizes that planning is essential to staying physically, financially, and emotionally healthy over the life span. As Massachusetts advances the Aging Agenda and addresses challenges and opportunities associated with the projected elder population growth, Elder Affairs is committed to finding more effective approaches to providing long-term services and supports that efficiently respond to the needs and preferences of individuals in need of functional support.

I encourage you to read the State Plan on Aging and to contact Elder Affairs with any questions. Additional information about programs and services can also be found on our website at [www.mass.gov/elders](http://www.mass.gov/elders).

Sincerely,

A handwritten signature in black ink, appearing to read "Ann L. Hartstein".

Ann L. Hartstein



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## Verification of Intent

The Massachusetts Executive of Elder Affairs State Plan on Aging is hereby submitted for the Commonwealth of Massachusetts for the period October 1, 2013, through September 30, 2017. Included are all assurances and activities to be implemented by the Executive Office of Elder Affairs under provisions of the Older Americans Act of 1965, as amended.

As the authorized and designated State Unit on Aging in Massachusetts and in assuming the roles and responsibilities as such, the Executive Office of Elder Affairs is responsible for developing the Massachusetts State Plan on Aging in accordance with the Older Americans Act and associated regulations, policies and procedures as outlined by the Administration on Community Living. The Plan addresses Elder Affairs' role as the leader relative to aging issues on behalf of all older persons in Massachusetts. Each program managed at Elder Affairs, along with each unit within the agency plays a role in the administration and delivery of services to elders and their caregivers and in so doing, supports the State Plan on Aging.

The Massachusetts State Plan on Aging for Federal Fiscal Years 2014 through 2017 is hereby submitted and has been developed in accordance with all federal statutory and regulatory requirements.

I hereby approve this Plan as His Excellency; Deval L. Patrick's designee and submit it for approval to the Administrator/Assistant Secretary for Aging, Administration on Community Living, U.S. Department of Health and Human Services.

Ann L. Hartstein, Secretary

Executive Office of Elder Affairs  
Commonwealth of Massachusetts

July 1, 2013

Date



## **The Massachusetts Executive Office of Elder Affairs**

The Massachusetts Executive Office of Elder Affairs (EOEA) became one of the nation's first cabinet-level agencies responsible for addressing the needs of elders in 1971. Originally a small advocacy agency, EOEA assumed its mandate to fund services in 1973 with the passage of legislation creating the Office. Today, EOEA directs services to thousands of elders across the Commonwealth through state and federally funded programs.

The aim of the Massachusetts State Plan on Aging 2014-2017 (State Plan) is to provide a structure for shaping the policy development, administration, coordination, priority setting, and evaluation of State activities related to the objectives of the Older Americans Act of 1965, as amended. The State Plan provides insight into programs, services and opportunities to support a comprehensive and coordinated system for serving elders and their caregivers in the Commonwealth. In aligning an agenda that builds greater capacity for home and community-based services, EOEA's vision reveals its pledge and passion for serving elders.

**Empower individuals to make their own choices based upon their preferences and desires and to encourage individuals to make a plan for achieving and sustaining quality of life goals, including aging in place with dignity, financial well-being and healthy aging.**

EOEA is responsible for the administration and oversight of programs and services on behalf of the over one million elders in the Commonwealth. Through a statewide network, EOEA provides services locally via Area Agencies on Aging (AAAs), Aging Services Access Points (ASAPs), Aging and Disability Resource Consortia (ADRC), Councils on Aging (COAs), and senior centers in communities across the Commonwealth. The work and collaborations are extended to all people in the Commonwealth who have functional needs and those who are caring for those individuals.

The growth in the elder population compels examination of existing programs to measure their efficiency and effectiveness in meeting the goals set for providing what people want and need. As people age, they generally have changing requirements for health care services and delivery systems, housing, long term care, transportation, economic well-being, socialization, nutrition, family and community support, and security. At the same time, they usually prefer to live independently, directing their lives to the fullest extent possible, and to participate in work and civic events as respected members of society.

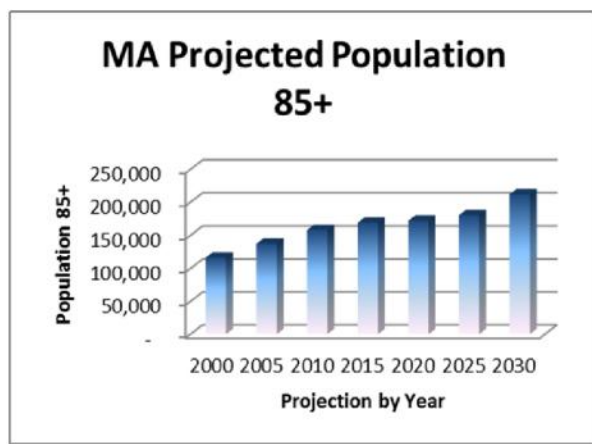
Under the direction of EOEA, the elder networks' commitment to its mission includes:

- Promoting the independence and well-being of individuals, their families, and caregivers through the development and delivery of quality services;
- Providing consumers with access to a full array of health and social support services in the settings of their choice;
- Informing consumers about all of their long term options, elder protective and advocacy services; and
- Encouraging individuals across the lifespan to adopt behaviors that will lead to healthy aging.



## **Executive Summary**

In 2013, Massachusetts seniors – people sixty and older – represent twenty percent of the total population, but with the explosion of aging baby boomers – people born between 1946 and 1964 – they will make up more than one quarter of the population in less than two decades. Not only will more people “age-in,” but more seniors will be living much longer than previous generations. In fact, life expectancy in Massachusetts, at 80.7 years, is greater than the national average and is sixth highest among the 50 states. People who live to be 65 may reasonably be expected to live another 20 years, with the 85+ cohort being the fastest growing segment of society.



U.S.Census Bureau, Population Division, Interim State Population Projections, 2005.

By 2020, people 55 and older will represent nearly 29% of the total United States population – an increase of 5% from 2010 – according to the Bureau of Labor Statistics (BLS). “The aging of the baby-boom generation has shifted the composition of the population toward older age groups, and this trend is likely to continue for the foreseeable future,” according to a BLS January, 2012 report. As the population increases, fueled by the numbers of baby boomers, older adults will be a more visible and vocal social force.

Among its major milestones, EOEA developed an “Aging Agenda,” to reflect the fact that aging is lifelong; that all of us share the journey from the moment of birth; and that early lifestyle choices often impact our path and later life destiny. The Aging Agenda (see Attachment E) offers nine principles for an optimal quality of life, including the elimination of “ageism” through on-going community participation and engagement. EOEA is committed to empowering older adults to take control of their lives, armed with information and services that offer them the options they need to live in dignity as respected, vital community members.

Looking ahead, EOEA’s strategic plan is designed to strengthen programs that support people as they address the changes associated with aging. Addressing a commitment to Community First – policy goals for supporting elders and people with disabilities to remain in or return to community living – the Aging Agenda is a roadmap for planning the lifespan progression from





youth to later life. EOEA's strategic plan is based on the nine principles of the Aging Agenda for achieving the best possible quality of life.

Massachusetts has been a national leader in anticipating and preparing to meet the needs and expectations of older adults. Having led the nation in requiring universal health coverage, the Commonwealth has been developing and enrolling citizens in a variety of person-centered integrated and long term care health plans such as the Program of All-Inclusive Care for the Elderly (PACE), and Senior Care Options (SCO). As a blueprint for the Affordable Care Act of 2010 (ACA), these integrated health and long term care plans offer consumers an integrated and comprehensive team of health care and long term care providers and services.

Another fundamental goal of Massachusetts' health care reform, reflected in the ACA, is the emphasis on prevention, wellness, and consumer empowerment. Local senior centers and COAs offer programs such as Chronic Disease Self-Management, Falls Prevention, a broad range of exercise classes, blood pressure screening, health benefits counseling, nutrition, congregate meals, and socialization. Consistent with the Commonwealth's commitment to Community First, EOEA's strategic plan is to offer seniors, their families and caregivers access to long term services and supports (LTSS) and highlight initiatives to improve the capacity, quality and availability of community-based LTSS. Successful delivery of community-based services requires the collaboration of Massachusetts Executive Office of Health and Human Services (EOHHS) agencies, non-profit and for-profit organizations, the business community, community leaders and individuals. Since many seniors rely on family and friends to provide "informal" care-giving, the EOEA strategic plan includes initiatives to increase supports and respite for informal caregivers.

An enduring goal of EOEA's strategic plan is the commitment to providing objective information to older consumers, their families and their caregivers – thereby empowering them to make choices best suited to their needs. In fact, emblematic of Community First is the Options Counseling program, available to all adults of any age, disability or income level to provide decision support regarding LTSS options. Counseling is available at any point in the treatment or care, even if consumers are in a nursing facility and want to consider alternative care settings. For people living in the community with chronic conditions, EOEA offers Chronic Disease Self-Management Education (CDSME) programs, and other evidence-based programs, empowering people with tools for managing their health. Performance and outcome measurements demonstrate the effectiveness of the CDSME programs, Falls Prevention and other evidence-based programs offered in Massachusetts.

Evidence exists that healthy diets and regular exercise leads to better physical health. Similarly, lifelong healthy lifestyle choices may eliminate or mitigate some of the chronic conditions prevalent in people over the age of sixty. People that save for later life needs earlier in their adult life commonly have more economic resources and, hence more choices as they age. Elders in this situation are more likely to have the money they need to pay for short- or long-term services and supports, provided in their preferred setting, which is at the core of the Massachusetts Embrace Your Future (see Attachment G) LTSS planning guide.





Similarly, sustaining one's interest and involvement in community life can help improve the well-being of both the community and the individual. Another Aging Agenda principle is the need to upgrade education and skills to enhance one's employability at a time when the US workforce is aging. According to the BLS, the number of seniors who are in the workforce after the age of 75 has increased by more than 140% over the last three decades and is anticipated to rise over the coming decades. Concurrently, the aging of the prime age (30 – 54) workforce will mean a decline in overall workforce growth as older workers retire and are not replaced.

EOEA also recognizes that seniors, for a variety of reasons, are choosing (or need to remain) in the workforce, in their current or new jobs. One of the core Aging Agenda principles and strategic goals is to expand personal planning and workforce opportunities for Commonwealth seniors, as well as public/private partnership initiatives for workers to continually upgrade their skill sets so they can strengthen their employability. For older adults who require training or re-training, EOEA's Senior Community Services Employment Program offers opportunities to develop a range of skills in a work setting.

EOEA is guided by goals that ensure positive outcomes and continuous improvement towards advancing a framework of programs and services that enhance its efforts to ensure the elder network develops and manages comprehensive and coordinated community-based systems for serving elders. EOEA's strategic plan goals include:

1. Expand income and financial support opportunities for elders, including employment benefits eligibility and personal planning.
2. Expand the capacity and availability of and enhance the quality of community based long term services and supports.
3. Increase the supports available to informal caregivers such as respite, training and information about support services, to encourage continuation of informal caregiving.
4. Protect and promote the well-being and quality of life of elders in the settings of their choice (community-based, facility-based, or healthcare settings).
5. Strengthen housing-with-supports options that support people living in the community and address the needs of people transitioning out of facility-based settings.
6. Attain and sustain the best possible physical, cognitive, and mental health and the opportunity to benefit from proven methods for maximizing and improving one's abilities, health and happiness.
7. Develop operational improvements that provide better service, quality and efficiency.



## **Massachusetts State Plan Context**

The EOEA's ambition is to empower individuals to make their own choices based upon their preferences and desires and to encourage individuals to make a plan for achieving and sustaining quality of life goals, including aging in place with dignity, financial well-being and healthy aging. In providing the information, social, economic, and health supports and resources people need to live safe, secure, connected lives in the setting of their choice, EOEA is furthering the goals of the Aging Agenda and its mission.

**Promote the independence and well-being of individuals, their families, and caregivers through the development and delivery of quality services; provide consumers with access to a full array of health and social support services in the settings of their choice; inform consumers about all their long term options, and elder protective and advocacy services; and encourage individuals across the lifespan to adopt behaviors that will lead to healthy aging.**

For decades, policy makers, service-providers, and analysts, projected the declining birthrate after 1964 against the expanding life expectancy and forecast that from 2011 to 2050; the result is the determination that our population would become significantly older. January 1, 2011 was the beginning of the early phase of this population change as 10,000 people daily are turning age 65. Two-thirds of all the people who have ever reached the age of 65 are alive today. Based on US Census projections, 2056 will mark the first time the population of 65 and older will outnumber people younger than 18.

As the agency charged with anticipating and preparing for seniors' needs over the next four years and through to subsequent decades, our providence for measuring housing, transportation, economic stability, nutrition, community services and personal security needs for elders and their caregivers is paramount. EOEA will continue working with consumers, advocates, state and federal agencies, private and non-governmental organizations, and academic institutions to develop strategies for helping people to live fulfilling, secure lives as they age.

The OAA of 1965 established a system whereby authorized program funds flow through State Units on Aging (SUA) (in Massachusetts, the SUA is EOEA) to Area Agencies on Aging (AAA) where they are used to support home and community based supportive and nutrition services. In Massachusetts, there are 23 AAAs representing a similar number of Planning and Service Areas (PSA). PSAs are collections of communities that any given AAA serves; PSAs in Massachusetts range in size and composition from a single city (for example, Boston) to ones that serve over 30 cities and towns. The partnership between EOEA and the AAAs in Massachusetts continues to be forged through caring, collaboration and commitment.

The State Plan serves as a blueprint for aging, and along with our website, [www.mass.gov/elders](http://www.mass.gov/elders), and [www.800ageinfo.com](http://www.800ageinfo.com), a resource for elders and their families.



## **Older Americans Act Core Programs**

Title III Programs originate within the OAA of 1965, as amended, which sought to bring focus and coherence to the national response to the needs of elder Americans. Title III and Title VII of the act authorize funding and provide parameters for operation of programs which address the entire spectrum of elders' needs through in-home and community based initiatives. Though special emphasis is placed on elders with particular economic or social need, all Americans over age 60 have access to Title III and VII programs. Title III and VII programs are grouped under the following broad categories as awarded to Massachusetts for Federal Fiscal Year 2013:

<u>OAA Funding Category</u>	<u>Federal FY 2013 Award</u>
Title III-B Supportive Services	\$8.2 mil
Title III-D Preventive Health	\$.4 mil
Title III-C1 Congregate Meals	\$9.8 mil
Title III-C2 Home Delivered Meals	\$4.4 mil
Title III-E Family Caregiver Services	\$3.1 mil
Title VII Elder Abuse Services	\$.1 mil
Title VII LTC Ombudsman Services	\$.3 mil
Nutrition Services Incentive Program (NSIP)	\$5.7 mil

In accord with the Code of Federal Regulations, 45 CFR 1321.1(c), the EOEAA, as the designated SUA and agency responsible for forecasting and distributing Title III and Title VII funding in the Commonwealth, is charged with the following task:

Each State agency designates planning and service areas in the State, and makes a subgrant or contract under an approved area plan to one area agency in each planning and service area for the purpose of building comprehensive systems for older people throughout the State. Area agencies in turn make subgrants or contracts to service providers to perform certain specified functions.

On the surface this assignment sounds routine; establish organizations across Massachusetts to build a framework that institutes services for elders – a bland, bureaucratic approach to elder services. The reality of community-based services for elders under Title III and VII of the OAA in the Commonwealth is quite the opposite – federal funding serves as the foundation of a vibrant system of long term care services that opens up possibilities and choices for elders in the communities they reside. As guided by the OAA, the current federal allotment of approximately \$32M leverages an additional \$41.5M in state, local, and other resources. Given the long and productive presence of OAA funding in Massachusetts, along with the current state service network of health care (MassHealth) and home care programs and services, Title III funding is a cornerstone of a \$3.0 billion plus elder services system.

### **Title III-B Supportive Services**

The Title III-B Supportive Services program provides home and community-based services that fund a broad array of services enabling elders to remain in the setting of their choice for as long



as possible. The program also funds multi-purpose senior centers that coordinate and integrate services for older adults such as congregate meals, community education, legal services, health screening, exercise/health promotion programs and transportation. A partial list of community-based services supported from Title III-B funding includes:

- Access services – transportation, case management, and information and assistance;
- In-home services – personal care, chore, and homemaker assistance; and
- Community services – legal services, mental health services, and adult day care.

One of the characteristics of Title III-B services funding is the autonomy it provides AAAs to “fill-in” services for elder consumers as needed. The AAAs can use Title III-B funding to offer elders a more complete package of services that in so doing allows the consumer to remain in the community setting of their choice. The delivery of health and home care services through state and federal programs are at the core of service delivery, but it is the flexibility inherent under Title III-B services that permits AAAs to “connect the dots” that permit seniors to thrive and live independently in communities. Title III-B services are available to address needs in communities that might otherwise not be addressed.

The 23 AAAs in Massachusetts are committed to offering a wide variety of services under Title III-B that address priority services, revealed elder needs and fills gaps where other programs fall short. A sample of Title III-B community services follow:

- Transportation services, medical and personal, are extensive within the AAA community; fulfilling a recurrent demand revealed through communications with elders and caregivers, focus groups, needs assessment projects, and surveys. Additionally, AAAs support local and statewide advocacy efforts to promote transportation options.
- Goals and activities that address social isolation include sponsorship of social gatherings for LGBT elders toward ongoing assessment of their needs and interests; socially isolated elders are matched-up with companions who help consumers remain in the community – providing assistance with meal preparation and shopping, or accompanying elders to medical appointments.
- In partnership with Title III-D funding, AAAs have pledged Title III-B funding to continue efforts to empower elders to live healthy lives through educational opportunities, remaining active, eating healthy, and sharing experiences; including Evidence-Based services that explore opportunities to lead healthier lives and seek direction and training on accomplishing that goal.
- In efforts to reach rural and isolated elders, outreach services continue to steer AAAs towards elders in need of information on a variety of programs and services. AAAs use several mechanisms to disseminate information and services, including newspapers and newsletters, media resources (television



and radio), speaker series presentations, and engaging opportunities for social connections.

- AAAs are specialists at providing Information & Assistance (I&A) services. In connection with the Aging and Disability Resource Consortia (ADRC) system, AAAs use I&A units to offer a “no wrong door” experience for consumers seeking information about services and benefits for adults with disabilities, elder adults and their caregivers. Under Title III-B funding, I&A services offer elders and caregivers the opportunity to make informed decisions about possible solutions.

### **Long Term Care Ombudsman Program**

A review of Title III-B funded programs would be incomplete without discussion of the Long Term Care (LTC) Ombudsman Program. The majority of the funding for the program is supported from Title III-B, with approximately 20% funded from Title VII funding. Composed of a state office and 24 local offices, the program works as a cohesive unit in offering ways for long term care residents and their loved ones to voice and resolve complaints.

A LTC Ombudsman is an advocate for residents living in long term care facilities. Ombudsmen offer a way for residents and their loved ones to voice complaints and have their concerns addressed so that residents can live lives with dignity and respect. Volunteer ombudsmen are assigned to facilities and have access to all nursing, and board and care facility residents; in Massachusetts board and care facilities are known as “rest homes”. The mandated visitation requirement is at least every other week, with a goal of working towards 100% weekly visits.

The LTC Ombudsman program strives to:

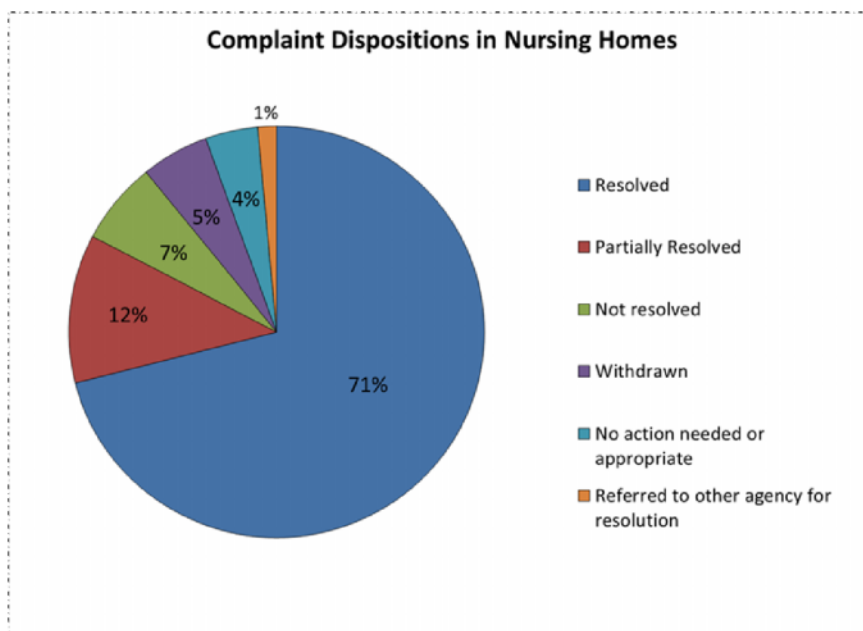
- Receive, investigate and work to resolve concerns of residents.
- Educate residents, families and providers about resident rights.
- Refer individuals to other appropriate agencies for assistance when resolution of a concern is not possible through the Ombudsman program.
- Advocate for positive change to the long term care system in Massachusetts.
- Provide information and assist consumers in selecting a long term care facility.
- Keep the identities of residents and complainants confidential unless the person making the complaint consents to having such information released, or abuse or neglect are involved.

EOEA offers monthly training to local offices through the Office of the State LTC Ombudsman on a variety of subjects including, effective interview techniques, regulatory updates and changes, and a review of case studies. Program managers are resourceful in linking with state



and community partners to actively support long term care populations. Transportation services under Title III-B support efforts to include nursing, and board and care facility residents in community services and programs. In an effort to reinforce the programs' presence, signs and program description pamphlets were recently redesigned, distributed and posted in facilities using Title III-B funding. Additionally, each facility was provided with a re-designed Residents' Rights poster.

The following chart indicates 2012 dispositions of complaints in Massachusetts nursing homes:



In support of the quality work associated with the Massachusetts program, the State Director and several local offices played host in 2012 to a group from the Elder Care Ombudsman/Advocates Office from Ireland. The focus of the trip to Massachusetts was to receive consultation on operating an effective and successful Ombudsman program. The group from Ireland met with EOEa representatives and visited several local offices, including touring local nursing homes.

### **Title III-C1 and C2 Nutrition Services**

Title III-C1, Congregate Meals, and III-C2, Home Delivered Meals, combine with other federal, state, local resources and consumer contributions to shape the Nutrition program in Massachusetts. Through a partnership between EOEa, AAAs, 27 Nutrition Projects, caterers, and volunteers, the program serves over 8.6M congregate and home delivered meals to eligible elders each year. Goals of the Nutrition program include:

- Reducing hunger and food insecurity;
- Promoting socialization of older individuals; and



- Promoting the health and well-being of older individuals and delay adverse health conditions through access to nutrition, other disease prevention and health promotion services.

Meals are provided at more than 400 congregate meal sites in Massachusetts and through home-delivered meals to senior citizens (age 60 or older) and people with a disability under age 60 who live in housing where congregate meals for elders are served. Each meal contains at least 1/3 of the current daily US Recommended Dietary Allowance of nutrients and considers the special dietary needs of elders. The congregate meal program provides at least one meal per day at senior centers, churches, schools, and other locations. Home delivered meals are provided to older individuals who are homebound due to illness, disability, or geographic isolation. Services are targeted to those in greatest social and economic need with particular attention to low income individuals, minority individuals, those in rural communities, those with limited English proficiency and those at risk of institutional care.

Nutrition Services help to address a number of problems faced by many elders, including poor diets, health problems, food insecurity, and loneliness. Key nutrition services include nourishing meals, as well as nutrition screening, assessment, education, and counseling, to ensure that older people achieve and maintain optimal nutritional status. In addition to the important dietary and social needs met by nutrition services, nutrition sites are encouraged to provide supportive services, primarily through the use of Title III-B services funding, if needed and not otherwise available to participants. The congregate setting provides opportunities for socialization and companionship. It also offers programs related to nutrition education, exercise activities, health promotion and disease prevention. Some programs also offer meals on weekends, and transportation (frequently a Title III-B funded service) is often available for those who have mobility concerns.

In recent years the demand to address diverse populations has initiated opportunities to offer meal and nutrition services to specific, diverse populations throughout the state, with all seniors welcome at all congregate meal sites. Current options for elders include: 7<sup>th</sup> Day Adventists Vegetarian meal site, Cape Verdean site, Chinese meal sites (8), Haitian meal sites (3), Hispanic/Latino meal sites (6), Indian meal site, kosher meal sites (10), LGBT meal sites (2), Russian meal site, and Vietnamese meal sites (3). A number of program elements and attractions are vital to serving diverse populations, including:

- Innovative, culturally sensitive menus;
- Culturally sensitive settings that are warm and welcoming;
- Multi-cultural languages spoken, multi-cultural staff/volunteers, culturally sensitive printed materials in the appropriate language;
- Exercise, tai-chi, health screenings – emphasis on healthy lifestyles and improving health status (Title III-B and III-D connection);





- Innovative and engaging nutrition education, delivered in participants' language, targeting food preferences of specific ethnic groups; and
- Nutrition assessment and education tailored to individual participants' needs.

Title III-C resources along with Nutrition Services Incentive Program (NSIP) funding will continue to shape the foundation of a flourishing Nutrition program in Massachusetts. As a means to achieving the goal of providing information and choices for community-based living, the Massachusetts Nutrition program has developed strategies over the next four years to increase outreach, provide expanded nutrition counseling, serve culturally appropriate meals and consider offering evening meals. As a first line of defense in assisting elders to remain in their communities of choice, nutrition services will continue to serve the OAA objective of "...a comprehensive array of community-based, long-term care services adequate to appropriately sustain older people in their communities and in their homes,".

### **Title III-D Preventive Health Services**

Title III-D programs under the OAA address disease prevention and health promotion services. Funding for these activities is intended to leverage non-Federal resources for developing programs designed to help older adults prevent/manage chronic disease and offer education and implementation activities that promote healthier lifestyles. Programs, services and information are provided at senior centers, meal sites, and other appropriate locations throughout each of the AAA localities. Programs that are supported by evidence-based foundations reduce the need for more costly medical involvement.

In connection with directives from the US Administration on Community Living (ACL), EOEA and the AAAs have fully committed to using the majority of Title III-D funding to provide Evidence-Based (EB) programs to elders. As defined by ACL, EB programs fall into three defined tiers with the goal for Title III-D activities to move toward the highest-level criteria. The highest tier criterion includes programs that have met the following measurements:

- Undergone Experimental or Quasi-Experimental Design; and
- Experienced full translation in a community site; and
- Disseminated products have been developed and are available to the public.

The goal of the network is to continue with efforts, as focused and enhanced in Fiscal Year 2013, to meet the directive from ACL to offer EB programs in helping elders live healthier lifestyles.

### **Title III-E Massachusetts Family Caregiver Support Program**

The Massachusetts Family Caregiver Support Program (FCSP) empowers elders and caregivers by providing information, education, support, and services that improve the ability of the caregiver to meet the needs of the care recipient while taking care of themselves. The FCSP is administered by EOEA in coordination with AAA/ASAPs throughout the Commonwealth. By recognizing that caring for a loved one can often be difficult and frustrating, EOEA recognizes



the potential emotional, physical and financial strain of caregiving, as well as its pleasures. The FCSP was established under Title III-E of the OAA to assist caregivers through the following services and supports:

- Information about caregiving, available services, community resources and local programs;
- One-on-one assistance to assess needs, identify options and gain access to community-based services;
- Training, support and counseling such as organizing caregiver support groups and training to assist caregivers in making decisions, solving problems and managing stress;
- Temporary relief services through in-home respite care, adult day care or emergency respite; and
- Supplemental services, on a limited basis, to complement the care provided by caregivers.

The FCSP in Massachusetts continues to evolve in developing and enhancing programs that connect caregivers to resources and information, and provide support services to caregivers and their families. The 23 AAAs in Massachusetts, as guided by strategies developed at EOEA, continue to address the needs of caregivers by developing consumer based programs, trainings, opportunities, and resources. Successful programs include; weekly support groups, respite opportunities for caregivers, one-on-one counseling, and community outreach and education opportunities. With over 4,000 caregivers providing services under counseling/support groups/caregiver training in Fiscal Year 2012, AAAs continue to offer caregivers a wide range of community options that educate caregivers and allow elders to remain in their communities.

As a method toward ensuring consistency among local programs in how caregivers are assessed, EOEA implemented a standard caregiver assessment approach and a specific assessment tool under the FCSP in 2012. The FCSP Caregiver Assessment requires that local programs use the approved assessment tool to assess caregivers, who are primarily experiencing stress, burnout, and/or have complex family situations, to determine what assistance the caregiver may need and the outcomes the caregiver wants for support. The assessment tool is designed to gather essential caregiver information and as a guide to focus on the caregiver.

Total expenditures for Fiscal Year 2012 for the FCSP approached \$4.0M including nearly \$2.9M in Title III-E funding and a total state, local and elder contribution share of \$1.1M. Additional caregiver program resources are available on the EOEA website, at [www.mass.gov/elders/caregiver-support/elders/](http://www.mass.gov/elders/caregiver-support/elders/).

### **Data Exploration – A Foundation for Elder Care**

In 2005, in partnership with Harmony Information Systems, Inc., EOEA made a significant investment towards upgrading the system of record for the home and community based service



network with the acquisition of Social Assistance Management System (SAMS). With this investment, the 27 homecare corporations (ASAPs), 28 nutrition programs, 23 local AAAs, and 22 protective service agencies became operationally bound by a single system of record; the Massachusetts Senior Information Management System (SIMS) system. The web-based system supports the full business cycle for home and community based care; information and referral, screening and assessment, care plan development, service plan development and delivery, consumer cost-share and provider invoicing, and FFP revenue claiming. The system also supports the investigative process for the Protective Services (PS) program.

Having completed the development and implementation of this system, EOEA is now realizing the benefits of this investment. Case management has been better standardized; inter-rater reliability has improved; and EOEA program monitoring capacity has exponentially increased. The dataset that emerged from this system serves as an integral policy tool. As an example, it helped guide EOEA in its significant program redesign of the homecare program as a result of the recent fiscal downturn. The depth and breadth of the SIMS dataset supported analysis of numerous scenarios which ultimately supported careful program modifications; mitigating the critical impact of the funding reductions to the frailer homecare program consumers.

In continuation of its goal to develop operational improvements that provide better service, quality and efficiency, EOEA has partnered with UMass Medical School (UMMS) in establishing HCBS Explore - a 'policy lab' purposed for Applied Home and Community Based Services (HCBS) Research. HCBS Explore is a business intelligence and analytics tool that uses Tableau software to present SAMS data in a dynamic, powerful, and visual way. The partnership of EOEA and UMMS has led to a comprehensive and robust reporting system that not only allows for daily operational discovery and direction, but also enables performance of more complex analytics for quality assurance/integrity and research.

In advancing the goal of developing operational improvements that provide better service, quality and efficiency, HCBS Explore is designed for success:

- Optimized for business intelligence: analysis, data visualization, predictive analysis;
- Simple table structure;
- Key reports and often-used roll-ups and summaries are already calculated; and
- No data is created by users, only queries.

The connection of the SIMS system to OAA core programs is through the ACL requirements to produce a State level report using the National Aging Program Information System (NAPIS). As a data collection arm of the SAMS system, NAPIS data provides unduplicated counts of consumers and caregivers, detailed characteristics of consumers and caregivers, expenditure data, a profile of service providers, and counts of service units. EOEA sponsorship of SIMS and promotion of NAPIS is critical to creating information systems that support informed decision-making and effective service delivery. Data serves as an instrument for promoting all OAA



programs, including the latest evidence-based services. The compilation of a comprehensive consumer management system is vital to providing program planners at the state and local level the tools to ensure that services reflect elder needs and provide maximum benefit.



## **In Support of Community Living**

A guiding principle behind elder care in Massachusetts, as advocated by ACL – through the OAA – and under the principles of Title III and VII, is the development and management of community-based programs and services. The ACA has also offered Massachusetts additional opportunities to integrate LTSS into the acute care system as well as to coordinate care across populations and address functional needs of people in need of functional support regardless of age.

Title III community-based services still form the foundation of engaging, vibrant communities for elders, their family caregivers and adults with disabilities. Effective planning, beneficial services and opportunities for community engagement provide choices for consumers to thrive in the community of their choice. By encouraging community living, the structures in support of choice and the means for progress, the network offers elders and caregivers vibrant opportunities to live, flourish and embrace life.

ACA enhances the efforts undertaken by the Massachusetts aging and disability service networks to build partnerships and shoulder responsibilities in support of Community Living.

The first federal Centers for Medicare and Medicaid Services (CMS) grant for care transitions was awarded to an ASAP led coalition on the North Shore of Massachusetts.

In order to facilitate communication between the ASAP network and physician practices, EOEA has developed a Physician Portal pilot to provide access for physicians, medical professionals and health care providers to view pre-set identified consumer/patient ASAP information in a “read-only” web-based format. As part of the pilot objective, an electronic medical record (EMR) would enhance care coordination and transition to home for shared patients/consumers as well as timely communication for patients/consumer care transition services.

### **Community Care Linkages: MA Aging Services Access Points Project**

In Massachusetts, nearly 140 care managers at the ASAPs were trained in the Coleman Care Transitions Initiative (CTI), making this workforce one of the first to have statewide capacity to use this evidence-based program to prevent re-hospitalizations.

The ASAPs used this training of its network workforce to initiate its Community Care Linkages (CCL) project in the fall of 2010 to create a ‘hard link’ between the health and functional needs of patients/consumers, thereby reducing unnecessary services – such as hospital readmissions and nursing facility admissions – while improving care transitions, and expanding community-based long term supports. In addition, its advocacy efforts have focused on inserting LTSS into the larger discussion and advocating for community-based care as a path to ensure consumers can live in the most integrated setting.

New strategic alliances were developed between ASAPs and hospital and physician networks, around such projects as the State Action on Avoidable Readmissions (STAAR) teams, Section



3026 Community Care Transitions Programs, Coleman CTI coaching, and evidenced-based healthy aging programs.

Other opportunities under the CCL project include ASAP collaborative initiatives with physician practices/patient centered medical homes (PCMHs), hospitals, skilled nursing facilities, Visiting Nurse Associations (VNAs), and Federally Qualified Health Centers (FQHCs) across Massachusetts. As an example, two Pioneer Accountable Care Organizations (ACOs) have contracted with three ASAPs to fund Community Care Coordinators, co-located in the practices, to engage in joint care coordination, participate in weekly high risk case review and provide enhanced access to LTSS for patients.

Projects have been funded from multiple sources including CMS Innovation Grants, Pioneer ACOs, Health Plans and Options Counseling. A Pioneer ACO pilot between Atrius Health, Southboro Medical Group and BayPath Elder Services ASAP has demonstrated significant reduction in hospitalizations and ER visits for shared patients. Four ASAPs are participating in the Pioneer Valley ACO post-acute work group to demonstrate best practices in care coordination and care transitions for patients with LTSS.

Reflective of the work EOEA is doing with the network to move the LTSS integration with health care forward and related to ACA efforts, the following efforts include:

#### **Community-Based Care Transitions – ACA Section 3026s**

The CMS Community-Based Care Transitions Program (CCTP), created by Section 3026 of the ACA, tests models for improving care transitions from the hospital to other settings and reducing readmissions for high-risk Medicare beneficiaries. The goals of the CCTP are to improve transitions of beneficiaries from the inpatient hospital setting to other care settings, to improve quality of care, to reduce readmissions for high risk beneficiaries, and to document measurable savings to the Medicare program.

There were 12 applications submitted by Massachusetts for the CMS Community Care Transitions Program (ACA section 3026) grants, of which four were approved and are in operation today. These four approved projects involved 20 hospitals and 12 ASAPs.

Some of applications that were not funded by CMS have been implemented as well on their own by the ASAP and hospitals in order to achieve better outcomes for consumers.

#### **Money Follows the Person**

MFP is a five year demonstration grant from the CMS awarded to the Massachusetts Office of Medicaid (MassHealth). Through the MFP demonstration, Massachusetts will move service funding from facility based settings to home and community based settings. The demonstration began in July 2011 and will run through 2016. Over 300 people have already been placed in the community and the demonstration will place an additional 1,800 people over the next three years from Long Term Care institutions to community settings.



Massachusetts is in the process of fully implementing the MFP waivers recently approved by CMS and expects to transition elders and people with disabilities to community living from institutional settings.

Additional work in support of community living in the Massachusetts aging network includes the following efforts:

### **Aging and Disability Resource Consortia**

EOEA, in partnership with the Massachusetts Rehabilitation Commission (MRC) and the EOHHS Office of Disability Programs and Policy, received a three-year grant from the ACL to develop an Enhanced Aging and Disability Resource Consortia (ADRC). The partnership provides access to an integrated system of community-based LTSS that are person-centered, high in quality, and provide optimal consumer choice and self-direction. EOEA has received \$700,000 for the first year and will receive up to \$840,000 for years two and three in order to achieve the following goals:

1. Develop an enhanced, financially sustainable “No Wrong Door” ADRC infrastructure that serves adults of all ages, disabilities and incomes; and
2. Demonstrate the ADRCs’ effectiveness in providing Options Counseling, supporting consumer direction and achieving positive consumer outcomes.

ADRCs were launched in Massachusetts in 2003, with significant support from the ACL and the CMS. There are now 11 ADRCs, serving the entire state and consisting of core partnerships between Massachusetts’ 23 AAAs, 27 ASAPs (20 of which are also AAAs), and 11 Independent Living Centers (ILCs), which provide peer to peer counseling and community based supports to adults with disabilities. By cross training staff and pooling expertise and resources, the ADRCs provide older adults and people with disabilities with seamless access to services and supports to help them remain independent in their communities. ADRCs use a “no-wrong door” approach, in which consumers are connected to the services and supports that best suit their needs regardless of which agency they contact first.

An ADRC coordinator has been hired who works with EOEA, MRC and EOHHS leadership, as well as regional aging and disability leaders to fulfill the following objectives:

- Stronger, enhanced local ADRC partnerships that ensure excellent, seamless customer service;
- Enhanced training for options counselors;
- An improved system of cross-training and cross-referral between ADRC partners and local service providers;
- Expanded local ADRC partnerships to better serve people with developmental and intellectual disabilities, mental health needs, cognitive impairments and veterans;





- Integration of ADRC services into new health care business models;
- A unified marketing strategy to inform health care providers who serve individuals at high risk of institutionalization about the ADRC partnership's role in the LTSS delivery system; and
- An enhanced performance management system for measuring and reporting on the performance of ADRC member organizations and consumer outcomes.

The project will develop a marketing strategy, new service models for partnering with integrated care organizations and similar/existing care management entities, standard policy and procedural manuals, a new Continuous Quality Improvement (CQI) Manual, and an enhanced invoice payment and service tracking capacity, where necessary and resources permit, for the VA Medical Centers (VAMC) to interface with the Massachusetts ADRC/HCBS system.

The project will build on lessons learned and systems developed under several recently completed grants from the ACL, which included the following:

- 2008 Nursing Home Diversion grant and a 2009 Community Living Grant, which strengthened the ADRC partnerships and increased the statewide availability of Consumer Direction;
- 2010 Enhanced ADRC Options Counseling Grant, which enabled Massachusetts to make Options Counseling more inclusive of Consumer Direction and more responsive to the needs of people with self-disclosed mental illness; and
- 2010 Care Transitions grant, which enabled Massachusetts to develop and evaluate an enhanced care transitions program to provide consumers recently discharged from an acute care setting with coaching and supports to help them avoid unnecessary re-hospitalization.

### **Chronic Disease Self-Management Education**

EOEA has partnered with the Massachusetts Department of Public Health (DPH), in receiving a three-year grant of \$1,725,000 in order to implement a Chronic Disease Self-Management Education (CDSME) programs in order to:

1. Significantly increase the number of older adults and/or people with disabilities with chronic conditions who complete evidence-based CDSME programs to maintain or improve their health status; and
2. Strengthen and expand integrated, sustainable service systems to provide CDSME in Massachusetts.

EOEA and DPH will collaborate with the Healthy Living Center for Excellence (HLCE), a partnership between Hebrew Senior Life and Elder Services of Merrimack Valley, which will



oversee daily operations for the grant and serve as a centralized source of leader training, technical assistance, outreach and recruitment, fidelity and quality assurance, data collection, partnership development, marketing and sustainability planning. EOE, DPH and HLCE will work with diverse networks that serve the target populations, including AAA/ASAPs, COAs, multi-cultural community agencies, community health centers and ILCs to achieve the following objectives:

- Increase capacity to provide CDSME in 11 out of 14 counties in Massachusetts.
- Develop a centralized infrastructure to provide CDSME throughout Massachusetts.
- Implement a business plan and develop strategies for sustainability.

CDSME project outcomes include:

1. A sustainable system of CDSME delivery;
2. A centralized and coordinated infrastructure utilizing six regional CDSME collaboratives;
3. Protocols for reimbursement from insurers;
4. Protocols for integration of CDSME into health delivery organizations and workplace wellness programs;
5. A partnership with one tribal entity; and
6. A business plan for sustainability.

CDSME provides a wide array of tools that can help those living with chronic health conditions and their caregivers learn how to better manage their conditions, develop personal goals, gain confidence and feel more positive about their lives, start and sustain healthier behaviors, communicate more effectively with healthcare providers, and make daily tasks easier. The workshops are designed to help participants better manage their chronic conditions. CDSME programs are taught by lay leaders and provide a wide array of tools that can help people living with chronic health conditions, including:

- Learning how to better manage their conditions;
- Developing action planning and problem solving skills; and
- Gaining confidence and self-esteem.

### **Evidence-Based Programs and Services**

The CDSME programs helped to advance the development of Evidence-Based (EB) program initiatives in Massachusetts and drive the healthy aging effort that has been developing over the



past several years. The aging networks' focus on healthy aging is supported by CDSME Program expansion and the continuing partnerships to promote EB programs linking EOEAs, AAAs, COAs, ILCs, the DPH Office of Healthy Aging and Disability, and the ACL. Following the official introduction in FFY2012 to EB programs through guidance from ACL, Massachusetts AAAs are providing six recognized programs in FFY2013. Together, with seven more EB programs added to the certified list for FFY2014, Massachusetts AAAs have embraced and are passionately promoting thirteen EB programs throughout the Commonwealth.

The train-the-trainer model has been adapted as a powerful method for promoting EB programs as well as generating enthusiasm for expanding programs. The nature of EB programs encourages community-wide collaborations and allows for expanded resources for training and program expansion. In support of evidence-based initiatives, AAAs have recognized the need to address ESL consumers and offered trainings in Spanish and Portuguese. Additionally, several AAAs have committed Title III-B Supportive Services funding along with Title III-D Health Promotion dollars for these efforts in FFY2013, and continue to do so on an ongoing basis.

In advancing the goal to attain and sustain the best possible physical, cognitive, and mental health and the opportunity to benefit from proven methods for maximizing and improving one's abilities, health and happiness, the planning figures for FFY2013 achieved 50% of the networks goal to reach 80% of Title III-D funding for EB programs. EOEAs anticipate full compliance with ACL guidance for FFY2014, with plans to include several more named EB programs that specifically address Falls Prevention; Stepping On, Otago, and Tai Chi-Moving for Better Balance. A strategy to promote healthy lifestyles, behaviors and strategies, with the adoption of EB programs, offers consumers practical choices that empower healthy aging – interventions resulting in positive behavioral changes.

### **Community Care Ombudsman**

The Community Care Ombudsman program (CCO) was enacted into law in November 1999. The CCO program created a statewide ombudsman service for elders living in the community and receiving community-based LTSS. The CCO program is designed to assist elders living in the community with any concerns they may have regarding services they receive in a community-based setting. The mission of the CCO program is to offer a safety net for dispute resolution and to foster collaboration to resolve community care problems.

The CCO program responds to complaints and issues regarding home and health community-based services including those provided by ASAPs, AAAs, home health agencies, private homemakers, adult day health programs and other community resources such as COAs, visiting nurses associations and hospice. In addition, the CCO program assists consumers in mediating any concerns and issues they may have when living in public and private housing complexes across the state. The program works closely with state agency staff at EOEAs, the Department of Housing and Community Development (DHCD), DPH, and the Massachusetts Office of the Attorney General (AGO) to mediate and resolve complaints and concerns that consumers have around housing services, contractor fraud (i.e.; carpenters, painters, and builders hired by elders),



and in-home home health aide abuse. Primarily, CCO staff work with AAAs/ASAPs and other service providers to identify and to address problems with individual caregivers and with non-performing providers after other grievance resolution processes have been exhausted. In addition, CCO staff ensures involvement of appropriate protective service agencies in situations involving abuse, neglect or personal endangerment.

EOEA collaborates with the elder service network to ensure consumers and agencies work effectively together to achieve satisfactory grievance resolution such that both parties are able to exercise their rights and responsibilities. The ombudsman's ability to leverage other existing resources and systems such as available grievance/appeal avenues, and the fact that most CCO assistance is provided by telephone, not face to face, allows the limited resources available to the program to efficiently respond to the current demand for assistance.

As the result of a 2012 Ombudsman Study conducted by EOEA, the CCO program has recognized that more visibility and training and more opportunity to make presentations to consumers about the ombudsman services are necessary. As a means toward evaluating possible expansion of the CCO program, future goals and strategies include:

1. Developing collaborative partnerships with other state agencies;
  - a. Developing protocols with DHCD management/local housing authorities for CCO information sharing;
  - b. Collaborating with DPH's Division of Health Care Quality Nurse Aide Registry to post a link to CCO through a website link;
2. Enhancing collaborative partnerships with federal and private entities;
  - a. Exploring possibility of establishing protocols with Housing and Urban Development (HUD) housing management;
  - b. Investigating possibility of coordinating information dissemination with private housing;
  - c. Exploring information dissemination with home health/social service agencies; and
  - d. Enhancing and develop training for COA staff to expand CCO assistance locally.

### **Alzheimer's Disease Supportive Services Program**

In September 2010, the EOEA received a two-year Alzheimer's Disease Supportive Services Program (ADSSP) grant in the amount of \$800,000 from the ACL. The purpose of the grant was to develop and implement a new set of Standards for Dementia Care for EOEA's Home Care Program in order to improve its capacity to identify individuals with Alzheimer's Disease and Related Disorders (ADRD), and connect them, along with their family caregivers, with dementia-capable services to help them remain independent in their own homes.



The goals of the ADSSP are to address four key elements in helping ADRD consumers and their caregivers:

1. Screening: Case managers and registered nurses at Massachusetts ASAPs administer the Mini-Cog screening tool for memory problems to all Home Care program consumers, with the exception of those who have already received a medical diagnosis of ADRD. The Mini-Cog consists of a word recall exercise and a clock drawing exercise and can be administered quickly, relative to other screening tools. Low-scoring consumers are vetted for alternate and temporary causes of reduced cognition, such as a reaction to medication or acute illness, and referred to diagnostic services and home care services specifically targeted to people with dementia.
2. Reducing Caregiver Stress: In adopting methods embraced by the Title III-E FCSP, EOEA has partnered with the Alzheimer's Association, Massachusetts-New Hampshire Chapter, to present 37 trainings reaching 552 caregivers with information on topics such as communication, activities of daily living, legal and financial issues, and signs and symptoms of dementia. In addition, Home Care staff, and FSCP (where appropriate), now distribute Alzheimer's Association Family Caregiver Guides (developed as part of the project) to families in order to provide caregivers with tools to improve communication and reduce caregiver stress.
3. Improving access to diagnostic services and treatment: Pending consent of the Home Care program consumer, letters are sent to Primary Care Physicians (PCPs) to advise them when a consumer has scored a two or lower on the Mini-Cog. The letters include a copy of the consumer's home care plan, and ask that the physicians discuss the results of the screening with the consumer, re-administer the screening if necessary, and monitor any worsening problems.
4. Increase availability, quality, and utilization of services: EOEA's future objective is to promote four services identified as being helpful to individuals with ADRD and their caregivers: Habilitation Therapy, Occupational Therapy Supportive Home Care Aid (SHCA) and Alzheimer's Adult Day. Moreover, the standards require that providers of SCHCA designate at least one RN to participate in a six-hour Train the Trainer session in Habilitation Therapy and to provide the trainings to their colleagues. All other vendors of personal care and homemaker services are required to provide a new basic training on ADRD to their direct care staff. Within the AAA/ASAP network, each ASAP is required to employ at least one RN who has been certified as a Habilitation Therapist to ensure the requisite expertise to procure, purchase, oversee the provision of, and evaluate the quality of services to persons with ADRD.



In 2012, EOEA partnered with the Alzheimer's Association, Massachusetts-New Hampshire Chapter, to oversee the development of a Massachusetts Alzheimer's Disease and Related Disorders State Plan. The two agencies convened a statewide Advisory Committee, consisting of people with Alzheimer's, family members, and representatives from state and local health and human service agencies, COAs, universities, hospitals, public safety agencies, and professional caregiver associations. The recommendations, goals and strategies are intended to be implemented over the next four years by EOHHS, EOEA and the Alzheimer's Association. The full Massachusetts Alzheimer's Disease and Related Disorders State Plan is located at the following link, [www.mass.gov/elders/docs/alzheimers-state-plan.doc](http://www.mass.gov/elders/docs/alzheimers-state-plan.doc).

### **Senior Medicare Patrol Program-Integration Project**

The primary goal of the Massachusetts Senior Medicare Patrol Integration Project (SMPI), formally concluding in June 2011, was to reach and engage rural and Native American Medicare and Medicaid beneficiaries to become better healthcare consumers. This was achieved through the development and implementation of innovative strategies on how to connect with these isolated and hard-to-reach elder populations and through the dissemination of the Senior Medicare Patrol (SMP) program message statewide. Target populations of the SMPI Project included Native American and rural elders, Medicare and Medicaid beneficiaries, their caregiver support systems, which include healthcare providers and other essential elder aging service networks. The scope of the SMPI Project reached all counties within the Commonwealth of Massachusetts with the SMP program message: Preventing healthcare errors, fraud and abuse.

The shared focus of the SMPI Project to integrate the SMP program message into the training curricula of certain state programs will continue into 2014 and succeeding years and include the FCSP, Money Management, Ombudsman, Protective Services, and SHINE programs. This objective has contributed to the enhanced visibility and understanding of the SMP Program mission by the above mentioned programs. As an example, the SHINE program has adopted training methods that recognize American Indian/Alaska Native (AI/AN) culture and as a result, have moderated the incidence of healthcare professionals raising barriers to healthcare services for the AI/AN people. Training for healthcare professionals serving AI/AN elders includes considering access barriers when arranging and providing care. EOEA will continue the SMP message to focus state programs toward increased awareness and understanding of healthcare programs in order to prevent fraud, error and abuse.





## **Person-Centered Planning**

As explained by the National Association of States United for Aging and Disabilities (NASUAD), *participant-directed services are home and community-based services that help people of all ages across all types of disabilities maintain their independence and determine for themselves what mix of personal assistance supports and services work best for them.* Person-centered services provide elders and their family caregivers a degree of choice and control over the LTSS they need to live in the community of their choice. Positioning elder consumer needs as the fundamental motivation toward designing and implementing services is the principal component in offering person-centered services. Promoting livable communities with consumer choice as a central theme guides the larger focus to design and implement programs that are person-centered.

Person-centered policies and programs must be at the heart of providing LTSS. The Massachusetts aging network remains committed to cultivating participant-directed services and points to the many examples currently in place. Some are humble in nature – the nearly 70 home delivered meal choices under the Massachusetts Elder Nutrition Program, while others are more intricate and involve multiple partnerships that generate collaborations across consumers, caregivers, providers, and policy makers. A focus on person-centered planning is vital to presenting consumer choice for home, community and institutional long term care services. Following are several illustrations of the Massachusetts networks' efforts in support of person-centered planning.

### **Massachusetts 2013 Statewide Needs Assessment Project**

In preparing for the State and Area Plans on Aging for Federal Fiscal Years 2014 through 2017, EOEA continued the enduring practice in Massachusetts of gathering information on the needs of the elder population. By engaging the elders that are served, as well as those that remain underserved and un-served, EOEA and the AAA network will use the Needs Assessment findings to focus Title III and state resources, highlight successes, and just as important - identify deficiencies. While the networks daily interface with elders and family caregivers reveals the services currently provided, the four year Needs Assessment Study brings focus on the efforts, choices and possible struggles that will require attention over the next four years.

A focus on participant-centered planning is at the core of the Needs Assessment process as it reveals individual needs and focuses on deficiencies in the network. Additionally, more routine methods for discovering elder feedback and service solutions are employed by AAAs, including:

- Examining program monitoring reports for trends and service benefits;
- Reviewing various consumer data resources; and
- Using other outside resources that allow the network to facilitate and support the development of participant-centered programs that address the needs of elders now and in the future.





Interpreting and identifying needs using multiple efforts facilitates the goal toward developing and delivering quality services that are directed toward and for elders and family caregivers. The 2013 Statewide Needs Assessment Report (see Attachment H) connects information collected from 23 AAAs to interpret data on the services most critical to enable elders to remain in their own homes with high quality of life as long as possible, and to empower older people to stay active and healthy. The Project measures how communities are prepared for the projected increase in population of elder residents, projected to be an additional 370,000 elders or 28% increase from 2010 to 2020.

AAA involvement included conducting needs assessment activities that addressed targeted consumer groups (e.g., rural elders, minorities, and low income elders) identified in the OAA. AAA activities targeted elders in social isolation, including elders living alone, LGBT elders, consumers with language barriers and other isolated populations. AAAs use the data to inform and direct their Title III funding decisions. Title III funding, through Area Plan Administration resources, ensure that elders and their respective caregivers and advocates have input in the local planning process and are participating in decision making. As an enterprise in coordinating over 4,700 consumers, providers, advocates, stakeholders and staff, the Statewide Needs Assessment Project communicates the needs of vulnerable population participants as well as those with greatest economic and social needs. The voiced top three areas of concern include transportation, foremost, followed by housing and health care.

A second arm of the Needs Assessment Project, the Municipal Questionnaire (see Attachment I), involved EOEA administering a web-based survey completed at the municipal level. COA directors were asked to complete the questionnaire for the municipality and were asked to report on:

- The current three top services to elders;
- The importance of 18 areas of concerns to their community;
- Services pertaining to transportation, safety and security, and staying active along with wellness promotion; and
- Their community's preparedness for serving the increasing number of elder residents.

A third effort in determining the needs of elder consumers and their caregivers is the employment of resources, data, and documents that allow the network to identify needs and facilitate and support the development of programs. While this last effort does not include AAA participation per se, the use of resources of this nature is vital to the larger project. AAAs use multiple external, as well as internal, resources in support of the services they provide elders and in support of their Area Plan on Aging.

In aspiring toward the comprehensive goal of well-being for elders, interpreting and identifying needs across multiple efforts facilitates the goal of developing and delivering quality person-centered services to elders and family caregivers. AAA review of the total "needs" picture will



guide the decision making process for awarding Title III resources. Emphasizing the findings of the Project will serve to identify the particular needs of each Planning and Service Area.

### **Evidence-Based Programs**

As a vital and focused response to the previous focus area, In Support of Community Living, beginning on page 14, the Massachusetts aging network of EOEA, the MA DPH, AAAs, ASAPs, and COAs continue to make a concerted effort to bring Evidence-Based (EB) programs to elders in the Commonwealth. A discussion of EB programs under the person-centered planning theme is instinctive, as elders explore opportunities to lead healthier lives and seek direction and training on accomplishing that goal.

As a nod to guidance from ACL, and in connecting resources across Title III-B and III-D, the goals set by EOEA and the Massachusetts AAAs imitate the following EB program goals:

1. Empower older persons to adopt healthy behaviors, improve health status, and manage chronic conditions better; and
2. Enable aging networks to have the capacity to deliver evidence-based programs.

Establishing goals that educate elders, implement activities supporting healthy lifestyles, and promote healthy behaviors, EB programs focus on attaining and sustaining the best possible physical, cognitive, and mental health that improves elders' abilities, health and happiness. The network is determined to establish a statewide infrastructure during the State Plan period for CDSME programs and establish a CDSME connection with medical/health care practices across the state. The plan is to develop a minimum of 25 partnership agreements with agencies that can reach large numbers of people on a continuing basis.

### **Massachusetts Commission on Falls Prevention**

The State Commission on Falls Prevention (CFP), assembled in 2013 and chaired by DPH, is a partnership of various players, including EOEA, that is charged with investigating and making a comprehensive study of the effects of falls on older adults and the potential for reducing the number of falls by older adults. The CFP will monitor the effects of falls by older adults on health care costs, the potential for reducing the number of falls by older adults and the most effective strategies for reducing falls and health care costs associated with falls.

The goal of the community-based CFP is to research and recommend strategies to the state for building of infrastructure to ensure that falls prevention programs are evidence-based and high quality, sustainable, adequately funded, and accessible to all communities. Individual objectives of the CFP include the following:

- Consider strategies to improve data collection and analysis to identify fall risk, health care cost data and protective factors



- Consider strategies to improve the identification of older adults who have a high risk of falling
- Consider strategies to maximize the dissemination of proven, effective fall prevention interventions and identify barriers to those interventions
- Assess the risk and measure the incidence of falls occurring in various settings
- Identify evidence-based strategies used by long-term care providers to reduce the rate of falls among older adults and reduce the rate of hospitalizations related to such falls;
- Identify evidence-based community programs designed to prevent falls among older adults
- Review falls prevention initiatives for community-based settings and
- Examine the components and key elements of the above falls prevention initiatives, consider their applicability in the Commonwealth and develop strategies for pilot testing, implementation and evaluation.

In the early stages of its mission, the CFP is in the process of developing a plan to inventory the number of community-based falls prevention programs available to older adults across the state using a Survey Monkey tool. In identifying the best way to capture current program information, the CFP is consulting with the Massachusetts COAs, Massachusetts Assisted Living Facilities Association (MassALFA), AAAs, housing authorities, YMCAs and other community organizations. The CFP is charged with developing a report that includes findings with recommendations and any suggested legislation to implement those recommendations. Program sustainability will be a key issue for the Commission to address in its future recommendations. The use of Title III-B and III-D funding may well play a significant role in expanding falls prevention programs throughout the AAA network.

### **Program of All-Inclusive Care for the Elderly**

The Program of All-inclusive Care for the Elderly (PACE) is a voluntary Medicaid Managed Care program for people age 55 and older, living in the community in a PACE service area, who are nursing home certifiable clinically, including all Medicaid and Medicare covered services, where primary care is given and coordinated by providers based in a PACE day center. To enroll in PACE the member need not be eligible for MassHealth or Medicare; however, a MassHealth clinician determines clinical eligibility regardless of financial eligibility status. Capitation rate is based on Dual or Medicaid-only status. PACE sites use an interdisciplinary team of clinicians in an expanded adult day health model to provide and manage all health, medical and social service needs. PACE was created as a way to provide consumers, family, caregivers, and professional health care providers flexibility to meet the health care needs of individuals and provide services in the community. There are currently six PACE providers with 13 sites in the Greater Boston, North Shore, and Worcester areas, serving 2,954 members.



### **Senior Care Options**

Senior Care Options (SCO) is an innovative voluntary fully integrated Medicaid and Medicare Managed Care Program, coordinating and paying for, through intensive case management and care coordination the full range of Medicaid and Medicare covered services, including long term care and home and community based services, for Dual Eligible and Medicaid only members age 65 and older. Medicaid Capitation Rates are based on geography, Dual or Medicaid-only status, and member clinical/setting status. Qualified senior care organizations have been selected to contract with MassHealth and CMS, and have established large provider networks that are coordinating and delivering all acute, long-term care, and mental health and substance abuse services. SCO is based on a geriatric model of care, and is available nearly statewide, with a total enrollment of 25,901 members.

The goals of both the PACE and SCO programs include documenting and ensuring program compliance; streamlining and consolidating reporting; ensuring quality outcome; and generating appropriate quality measures and meaningful marketing. In an effort to market PACE and SCO, Massachusetts is involved in the following strategies toward program outreach:

- Continuing a 2012 legislatively mandated mailing to all MassHealth members age 65 and older notifying them of SCO, PACE, and the ASAP network (100,000 notices sent in total).
- The month prior to each MassHealth member's 65th birthday, EOEA mails a birthday card to that member informing them of the SCO program (approximately 200/month).
- MassHealth sends a standard eligibility notice which references SCO and PACE to each MassHealth member enrolled in a MassHealth MCO turning 65.
- MassHealth Standard members that are age 65+ and un-enrolled in SCO and PACE, will be sent a postcard informing the member of the SCO program (pool of approximately 80,000; rate of 4,000/month).
- SCO and PACE programs conduct their own marketing pursuant to CMS and MassHealth approval of the materials; adhering to CMS marketing requirements.

### **Long Term Care Options Counseling**

Long Term Care Options Counseling (LTCOC) is a gateway for many Massachusetts elders and people with disabilities to receive community services and supports. Launched throughout the Commonwealth in 2010, LTCOC provides residents with objective information on LTSS and supports that can make the difference between people remaining in their homes or other preferred residential setting or placement in a nursing facility.



The program ensures that elders and people with disabilities have the opportunity to consider long-term support options at a variety of points in the LTSS planning process, not just prior to nursing facility admission. An Options Counselor provides unbiased information, reviews options, and supports the individual in determining a plan for service and the steps to achieve it to allow the consumer to live in the setting of choice. LTCOC consumers are provided access to the full menu of available long term care services available. The timing and the number of counseling sessions provided depend on a consumer's individual need for information, decision making support, and is accessible through the Commonwealth's 11 ADRCs. Counselors are located at ASAPs and ILCs.

In an effort to expand income and financial support opportunities for elders, including employment, benefits eligibility and personal planning, the LTCOC program has designed measurable objectives that include strategies directed to individuals, caregivers and family members in community settings, hospitals, rehabilitation facilities and nursing facilities. Additionally, the LTCOC program plans enhanced ASAP/ILC IT systems to coordinate cross referrals for options counseling services. The work plan is to develop capacity to track Options Counseling referrals and facilitate cross-referrals through "cloud-based" technology solution to interface the two data systems used by ASAPs and ILCs.

### **Serving Health Insurance Needs of Elders**

The Serving Health Information Needs of Elders (SHINE) program provides trained volunteer health benefit counselors that provide free, accurate, unbiased information and assistance regarding health insurance and benefits to elders, Medicare beneficiaries, family members, and professional caregivers. EOEA administers the SHINE program in partnership with elder service agencies, social service and community based agencies and COAs, with SHINE counselors working at senior centers, elder service agencies, Independent Living Centers (ILCs) hospitals, and other community locations.

The SHINE program is focusing future efforts on building stronger collaborations with other state agencies and replacing the current in-person certification training with a condensed six day in-person/six day online format for SHINE volunteer counselors. Additional objectives for the program include counseling Medicare beneficiaries to better understand the full range of health insurance options available to them using the following measurements, with FY12 as the base year:

1. Percentage of growth in number of screenings for public benefits programs;
2. Percentage of growth in number of SHINE consumers counseled on the full range of health insurance options; and
3. Percentage of growth in consumer financial savings as a result of SHINE counselor intervention.



## **The Case for Elder Justice**

In addressing the ACL goal of ensuring the rights of older people and preventing their abuse, neglect and exploitation and in connection with the EOEAs focus on preventing and responding to reports of elder abuse, the Massachusetts aging network directs an elder rights protection program that is focused and responsive. EOEAs partnership with AAAs and the aging network continues to focus on a variety of approaches to accomplish the goal of ensuring the rights of elders. Services are always offered and provided based on the wishes of the elder and employ the philosophy of ‘least restrictive, appropriate intervention’. Strategies focus on elder neglect and abuse prevention, advocating for elders’ rights within long-term care facilities, continuing support of legal services for elders and the emerging role of legal assistance development at the state level. Title III-B and VII Federal funding links with approximately \$16.2M of State Protective Service funding, creating increased opportunities to develop new choices and strengthen the elder rights protection activities in Massachusetts.

EOEA and the aging network continue to work diligently to protect the most vulnerable elders, those who experience abuse, neglect and financial exploitation. Risk management tools assist local protective service workers and supervisors in identifying elders, who are the most vulnerable and are at highest risk of harm, for immediate attention while allowing lower risk cases to be triaged to other services. Implementation of a new Protective Services data system allows for continuous quality assurance and quality improvement activities through case record reviews and monitoring protective service activity reports. Partnerships across community organizations focus on a variety of approaches to accomplish the goal of protecting the rights of elders.

### **Protective Services**

EOEA is required by law to administer a statewide system for receiving and investigating reports of elder abuse, and providing needed protective services to abused elders when warranted. To fulfill this responsibility, EOEAs has established 21 designated Protective Services (PS) agencies throughout the state, along with a 24-hour, 7 day a week Elder Abuse Hotline, Guardianship Services and the Money Management Program.

Elder abuse includes physical, emotional and sexual abuse, neglect by a caregiver, self-neglect (added as a reportable condition in July 2004) and financial exploitation. To encourage elder abuse reporting, Massachusetts state law requires certain professionals to report suspected incidents of elder abuse. Persons who are not mandated reporters may also make elder abuse reports. Mandated reporters who fail to make elder abuse reports when appropriate are subject to a fine up to \$1,000. In addition, the law provides mandated reporters with immunity from civil or criminal liability that otherwise could result from making a report, provided the reporter did not commit the abuse. Persons who are not mandated reporters have the same immunity as long as they report in good faith.





In fiscal year 2012, 19,951 elder abuse reports were received. This represents an 8% increase over fiscal year 2011 intakes. There were 5,406 newly confirmed cases of elder abuse; representing a 16% increase over fiscal year 2011 cases. Over the 25 years since the program's inception, intake numbers have continued to rise, varying from 5% to 12%.

Activities of the PS program are developed and implemented to support a focus on investigating reports of abuse, neglect or financial exploitation and offer appropriate services or interventions to those who are determined to be at risk of future abuse. In support of this effort, EOEA and the elder network have implemented the Adult Protective Services solution (APS) as a flexible, web-based integrated case management system configured specifically for PS agencies and based on industry best practices. As a component within the SIMS system, the APS solution addresses a range of needs reported by PS agencies, including:

- Designing workflows that help workers clearly follow the steps throughout the APS process from intake through investigation;
- Developing management tools that help ensure proper supervision of PS staff; and
- Reporting and automating business processes that provide clear alignment between actions and policies and procedures.

The goal of the PS program is to prevent, remedy or eliminate the effects of abuse on the elder. While the primary focus is on ending or alleviating the abuse, other critical program goals include: freedom, safety, least disruption of lifestyle and the least restrictive care component. An elder's right to self-determination must be respected to the fullest extent possible, and the least restrictive appropriate service alternatives should be used to meet the needs of the elder.

The following programs and services highlight Massachusetts activities to prevent, detect, assess, intervene, and/or investigate elder abuse, neglect and financial exploitation.

*Elder Abuse Hotline:* To address the State's legal mandate to allow for the receipt of reports on a 24 hour basis, the Elder Abuse Hotline operates 24 hours per day, 365 days per year. During business hours, calls to the Hotline are automatically routed to the appropriate PS agency to take the report. After business hours and on holidays and weekends, the Hotline is staffed to take the report, assess the immediacy of each situation, and immediately page out all emergency and other urgent situations to on-call staff from the PS program.

*Guardianship Program:* EOEA has contracts with five not-for-profit agencies across the state to provide conservator and guardianship services to PS consumers who are unable to make informed decisions and are at risk of serious harm. A conservator is appointed by the court to manage the finances of another person, while a guardian is responsible for managing both the financial and personal care needs of his/her ward. This program is able to serve up to 170 elders at a time, and is usually at capacity.





*Training Initiatives:* EOEa continues to provide specialized training and consultation on sexual abuse by establishing a Sexual Abuse Consultation Group composed of workers and supervisors from the PS agencies. Guided by an expert in the field, the group meets quarterly to discuss cases and share expertise with other group members. The contracted professional is also available to this group to discuss cases as they are being investigated. EOEa has utilized contracted professionals to provide advanced training in supervision for the PS supervisors, including future plans for assistance on complex financial exploitation cases.

*Outreach:* Public education is conducted on a local, regional and statewide level. Much of the local outreach and education is directed at mandated reporters and is conducted by the 21 designated PS agencies. Interagency collaborations are encouraged, with some interagency and interdisciplinary teams meeting regularly to address elder issues shared by the disciplines. EOEa conducts outreach at the regional and state level through cable television programs, radio shows and interviews with print media as appropriate. PS staff at EOEa, often in partnership with the local programs, participate in conferences that reach out to large groups of professionals.

Recent conference appearances include presenting at the Massachusetts Councils on Aging Conference on “Abuse in Later Life: When Is Elder Abuse Domestic Violence” and collaborating with the Disabled Persons Protection Commission, law enforcement, prosecutors, agencies providing services to the disability population and the Attorney General’s Office to plan and present a conference titled “From Crime Scene to Sentencing and Beyond: Addressing Crimes Against Persons with Disabilities and Elders”. Additionally, EOEa presented at the annual Fire Services conference for firefighters on how to respond to Hoarding Issues. Future collaborations include participation on a panel presentation to the Sexual Assault Nurse Examiner (SANE) Nurses at their annual conference.

*Protective Services Collaborations:* EOEa continues to partner with a variety of disciplines to provide education, enhance relationships, and foster preventive initiatives for elder abuse, neglect and exploitation.

*Banks and Credit Unions:* EOEa continues to provide training to bank personnel through the Bank Reporting Project which is a collaborative effort between EOEa, Massachusetts Bankers Association and the Attorney General’s Consumer Protection Division. The project was expanded to include Credit Unions and EOEa PS staff worked with the Massachusetts Credit Union League to amend the bank reporting manual to reflect the practices of credit unions. A manual titled



“Dealing with the Financial Exploitation of Elders” was produced and distributed at the credit union trainings.

Financial Planners: EOEA is currently partnering with the Massachusetts Financial Planners Association to provide training to certified financial planners on how to work with consumers who might have Alzheimer’s or other age-related dementias, and how to identify potential financial exploitation of their clients. Development of a curriculum in partnership with the Financial Planners Association and the Alzheimer’s Association is being designed, with the goal of providing either one central training or regional training.

MA Alzheimer’s Disease and Related Disorders (ADRD) State Plan: EOEA’s PS staff sits on the Steering Committee for the implementation of the ADRD State Plan and is represented on a workgroup addressing financial exploitation of persons with Alzheimer’s Disease.

Collaboration across State Agencies: EOEA collaborates with several state agencies. PS has representation on the Steering Committee of the Building Partnerships Initiative (BPI), which links law enforcement, adult protection, human services and others to address violence committed against persons with disabilities using a multidisciplinary approach. The Steering Committee meets quarterly and provides outreach and training to a variety of service providers.

The Director of PS represents the Secretary of EOEA on the Governor’s Council to Address Sexual and Domestic Violence. The Lieutenant Governor chairs this interdisciplinary council that consists of 30 community-based experts appointed by the Governor, and representatives of various state agencies responsible for sexual and domestic violence service providers throughout the Commonwealth.

EOEA sits on the Home Oxygen Safety Taskforce convened by the Department of Fire Services to educate users and address the risks of home oxygen use, particularly smoking and oxygen use.

PS has received a Violence Against Women Grant (VAWA) from the Executive Office of Public Safety and Security to provide cross training between PS, Domestic Violence (DV) agencies and providers of Sexual Assault (SA) services. EOEA is in the second year of the grant which provides training on elder issues to domestic violence and sexual assault service providers and trains local PS staff on the services available to their consumers who are victims of sexual assault or domestic violence. The grant also fosters relationships between PS staff and staff at the community DV and SA agencies.

Medical Partnerships: EOEA’s PS staff provides yearly training at the Massachusetts College of Pharmacy and Health Sciences to students in the



physician's assistant classes and other CEU programs. EOEAs PS staff also provides a yearly training at the Regis College Nurse Practitioner Program.

**Prevention:** The Massachusetts Money Management Program (MMMP) is a jointly sponsored venture with the AARP Foundation and Mass Home Care. The MMMP seeks to prolong independent living in the community for elders who are unable to handle certain financial matters. The program is a free service that assists low-income elders who might be at risk of losing their independence due to their inability to pay basic rent, food and utility bills on time. By using trained, insured, supervised volunteers, consumers are assisted with check writing, balancing checkbooks and ensuring bills are paid in a timely manner.

**Protective Services Future Plans:** The EOEAs Strategic Plan includes a goal to protect and promote the well-being and quality of life of elders in the settings of their choice. One initiative is to strengthen the PS program by enhancing protective response to Financial Exploitation cases. To this end, PS will be convening a multidisciplinary team to study the current response to financial exploitation and make recommendations to strengthen the response. To measure outcomes, EOEAs is currently using data from the APS case management system to determine the percent of financial exploitation cases with reduced level of risk at the time of disposition on a quarterly basis.

### **Long Term Care Ombudsman**

As addressed above under the "Older Americans Act Core Programs", a LTC Ombudsman is an advocate for residents living in long term care facilities. Ombudsmen offer a way for residents and their loved ones to voice their complaints and have their concerns addressed so that residents can live their lives with dignity and respect. While revealed under Title III-B services as a key component of AAA services, it is as germane to promoting elder rights under Title VII funding that the LTC Ombudsman program be included within Elder Justice.

Additional information on the LTC Ombudsman program, including resident's rights, can be found at [www.mass.gov/elders/service-orgs-advocates/ltc-ombudsman/](http://www.mass.gov/elders/service-orgs-advocates/ltc-ombudsman/).

### **Community Legal Services**

The Legal Advocacy and Resource Center (LARC) of Boston, MA, in partnership with EOEAs, was awarded an ACL grant under the Model Approaches to Statewide Legal Assistance Delivery Systems in 2010. The grant supports projects that expand or improve the delivery of legal assistance to elder residents, with a focus on assisting those in greatest economic or social need, and increasing the quality and quantity of elder legal services. During FFY2011, the Massachusetts Senior Legal Assistance Project (MSLAP), under the direction of the Legal Assistance Developer (LAD), developed and promoted a legal helpline to serve as a first point of contact for elders who are experiencing legal problems, and provide them with information, advice and referrals in a timely fashion. By better triaging callers to the service that most



effectively and efficiently meets their needs, the helpline ensures that the maximum possible number of elders with legal challenges have their issues addressed and resolved.

As an outcome of the MSLAP, the network saw increased elder access to legal services, by increasing the capacity of legal agencies to serve a greater number of consumers. The principal purpose of the MSLAP is to increase seniors' access to legal services, by increasing the capacity of legal agencies so they can serve a greater number of consumers. Through increased efficiency and simplification of referrals among agencies, the MSLAP seeks to maximize efficiency of existing legal networks. The AAA network has assisted with marketing the helpline through the delivery of a communiqué, including translations in French, Portuguese, Russian and Spanish. In partnership with the AAAs, the legal helpline provides a more unified consortium to serve elders throughout the state toward increasing access to legal services.

Fiscal year 2012 data reports that the AAAs in Massachusetts contracted with nine separate legal service providers in providing 27,286 legal services units (measured by the hour), with funding through Title III-B of \$1.25M and non-federal resources of \$0.8M. Legal services provided to elders accounts for approximately 7% of all Title III funding, following only congregate/home delivered meals, caregiver and Information & Assistance services in total Title III funding. With guidance from the LAD, EOEA and the AAAs have initiated a renewed focus on legal services and are optimistic for the Massachusetts application to Phase II of the Model Approaches to Statewide Legal Assistance Delivery Systems ACL grant.

The financial and economic crisis of the past few years has created a larger demand for consumer legal services. Legal service agencies in Massachusetts use various methods to protect elder rights, including: restoring benefits to elders and persons with disabilities; addressing housing and foreclosure issues; working to keep elders independent within the community through education and information sessions at senior centers; and managing custody issues for grandparents. The AAA network has also remained active in state and national legal services organizations – membership and leadership on various organizations have proven vital in furnishing support for elder consumers as well as reinforcing the important role legal services plays in maintaining elder independence.



## **Goals, Strategies, Initiatives and Metrics**

In an effort to ensure positive outcomes and continuous improvement, EOEA's core value continues to be its commitment to consumer involvement, teamwork, collaboration, cooperation and respect; and to managing services in a person-centered, outcome focused manner. The EOEA senior leadership team, working with program managers, surveyed programs to develop goals, strategies and initiatives that will continue to expand access to programs and insure program integrity across EOEA. While strategies and initiatives are punctuated throughout the State Plan in support of specific goals, what follows is a complete inventory of EOEA's goals, strategies and initiatives covering the State Plan period. It includes seven goals and the strategies and matrices to measure program effectiveness and agency efficiencies.

### **Goal #1 – Expand income and financial support opportunities for elders, including employment, benefits eligibility and personal planning.**

Economic security is the cornerstone for every person to be able to live a productive and meaningful life. Without the opportunity to achieve financial security at every age, people are less likely to be able to reach their full potential in their work, health, emotional and civic life.

#### **Strategies to attain this goal:**

1. Increase awareness and educate elders (and individuals with disabilities) and caregivers through SHINE, AAA/ASAPs' information and referral system, and senior scene segments about the range of federal, state and local income and benefits support programs available to elders.
2. Enhance access to state training for SHINE volunteer counselors.
3. Sustain local access at COAs to provide information about aging and civic opportunities for individuals and families.
4. Support elder employment opportunities for individuals and work with stakeholders on systemic income and financial support needs of older adults.
5. Through LTCOC, provide 1:1 decision support regarding long term services and supports options to elders and people with disabilities to ensure informed choice and support living in the least restrictive setting

The following initiatives, with measures to track progress, will be used to support Goal #1 strategies:

- Counsel beneficiaries to better understand the full range of health insurance options available to them.
  - ✓ Metrics ~ Several metrics will measure the percent of growth in the number of consumers served annually ranging from 2 – 5%.



- Replace current 12 day in-person certification training with a condensed six day in person/six day online format for SHINE volunteer counselors.
  - ✓ Process Milestone ~ Completed by June 30, 2014
- Outreach through public presentations, cable TV, radio and other media.
  - ✓ Process Milestone ~ Produce a monthly “Senior Scene” cable show and track downloads from MassAccess TV quarterly.
- Promote training opportunities for older workers in the Senior Community Services Employment Program (SCSEP) through on the job training, job clubs and more targeted host site selection.
  - ✓ Metrics ~ Measure quarterly the percent of SCSEP participants entering unsubsidized employment each year and percent of SCSEP participants employed six months after hire date.
- In partnership with Executive Office of Labor and Workforce Development (EOLWD) and local Workforce Investment Boards, educate employers about the aging workforce and the urgent need to plan for hiring and retaining older adults, as part of a cogent workforce plan for their businesses.
  - ✓ Process Milestones ~ In support of the SCSEP State Plan 2012 -2015, establish ten new industry-driven training pipelines (local employers) per year.
- Provide LTCOC to individuals, caregivers and family members in community settings, hospitals, rehabilitation facilities and nursing facilities.
  - ✓ Metrics ~ Number of consumers served by Options Counseling and percent of consumers better able to make informed decision about LTSS post LTCOC (using a customer satisfaction survey).
- Educate consumers and providers regarding the provision of LTCOC services, including, hospital discharge planning staff and rehab and nursing facility staff, COAs and I&R network.
  - ✓ Process Milestone ~ Develop options for implementing an outreach plan.
- Continue promotion and use of the Embrace Your Future booklets to improve consumer awareness of Long Term Care (LTC) planning needs and options.
  - ✓ Process Milestone ~ Distribute the remaining 5,000 booklets at community events over the next 2 years.
- Collaborate with other state agencies.
  - ✓ Process Milestone ~ Execute MOU with Department of Transitional Assistance (DTA) on concerted Supplemental Nutrition Assistance Program (SNAP) outreach and enrollment activities.



- Provide training to COAs about employment services and through Massachusetts Council on Aging (MCOA), support elders seeking employment assistance.
  - ✓ Metrics ~ Number of individuals contacting COAs about civic engagement opportunities or employment services annually, and number of COAs (totaling 20 or more per year) incorporating Job Search Services Program into COA programming .
- With COAs, promote the EOEA civic engagement web page on [mass.gov/elders](http://mass.gov/elders).
  - ✓ Metric ~ Number of elders volunteering 10+ hours annually in civic engagement activities sponsored by COAs.

<b>Goal #2 – Expand the capacity and availability of and enhance the quality of community based long term services and supports.</b>
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Without access to quality long term services and supports, it will be difficult for individuals who need assistance with activities of daily living to live on their own in a community setting. Workers who are well trained and available to provide this support are critical to achieving the Community First initiative goal of providing everyone with the option of living in the setting of their choice.

**Strategies to attain this goal include improving training, expanding the LTSS workforce and expanding access to quality HCBS in the following ways:**

1. Improve training of and increase the long term services and supports workforce.
2. Expand access to home and community based services in order to help individuals transition out of facility-based care or prevent unnecessary institutionalization.
3. Monitor the quality of long term services and supports provided via the home and community based services system.
4. Continue to strengthen the links between the disability and aging networks through ADRCs.
5. Ensure elder transportation needs are considered within state initiatives.
6. Increase enrollment in SCO and PACE.

Goal #2 strategies will be supported by the following initiatives with measures to track progress:





- Develop new improved training curriculum for Personal Care Attendants (PCAs) and Personal Care (PC)-homemakers under the Personal and Home Care Aide State Training (PHCAST) grant (EOEA & EOHHS co-lead).
  - ✓ Process Milestone ~ Disseminate the state's new core training curriculum for direct care workers (personal care assistants and personal care homemakers) to direct care workers via state agency contractors, employers, union-sponsored training systems, and community colleges. This work is ongoing.
  - ✓ Process Milestones ~ Devise a strategy for sustaining a “train the trainer” system that would authorize trainers to deliver the curriculum in a manner faithful to its adult learner style of instruction and use a training registry to aid workers in demonstrating to employers what types of training they have acquired. This work is ongoing.
- Introduce new training into new training venues.
  - ✓ Process Milestone ~ 15 sites actively offering trainings by December 31, 2013.
- Implement formal process for communicating desire for leaving long term facility-based setting (via Section Q).
  - ✓ Metrics ~ Number of Section Q referrals received by the Comprehensive Screening and Service Model (CSSM) and number of persons counseled by CSSM and transitioned to community setting on a quarterly basis.
- Increase the participation in Money Follows the Person (MFP).
  - ✓ Metrics ~ Number of MFP participants and applicants monthly.
- Enhance state Home Care (HC) Basic, Enhanced Community Options Program (ECOP), and Community Choices programs, which serve nursing facility eligible consumers and frail elders.
  - ✓ Metrics ~ Number of state home care consumers; Average length of stay in home care programs (ECOP, Frail Elder Waiver (FEW), HC Basic); and the number of Nursing Facility (NF) eligible consumers who live in the community with Home Care supports, all on a quarterly basis.
- ASAP procurement/designation case review for Home Care and Clinical Assessment and Evaluation (CAE) programs.
  - ✓ Process Milestone ~ Conduct nine site reviews annually.
- Monitor CMS required quality performance measures for the FEW.
  - ✓ Metric ~ Percent of Waiver consumers whose level of care have been determined using the clinical assessment tool every 12 months.



- Conduct cross-training of ILC and ASAP staffs.
  - ✓ Process Milestone ~ Each ADRC to conduct six cross-trainings annually.
- Build up cross- referrals between ILC and ASAP sites.
  - ✓ Process Milestone ~ Ongoing development of target for cross-referrals.
- Expand partnerships to include agencies that provide behavioral health services and serve people with intellectual and developmental disabilities.
  - ✓ Process Milestone ~ ADRCs will develop partnerships to expand statewide coverage of an ADRC serving all populations and payers, including elders, individuals with intellectual and developmental disabilities, family caregivers and private paying individuals. This work is ongoing.
- Participate in the state EOHHS Transportation Workgroup.
  - ✓ Process Milestones ~ Attend workgroup sessions advocating for transportation needs of seniors; Conduct legislatively mandated study on the Impact of Massachusetts Bay Transportation Authority (MBTA) Fare Increase on elders and people with disability with the MA Office for Disability.
- Collaborate with SCO and PACE providers on additional marketing activities.
  - ✓ Metrics ~ Increase annual SCO enrollment by 20% and annual PACE enrollment by 10% in FY13 and FY14.

<b>Goal #3 – Increase the supports available to informal caregivers such as respite, training and information about support services, to encourage continuation of informal caregiving.</b>
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Informal caregivers play a significant role in the LTSS system. It is estimated, as stated by the national group Family Caregivers Alliance, over 85% of all assistance received by people in their community setting is provided by spouses, children, other family members, relatives or friends. This informal support is a major addition to the formal supports that are part of the LTSS system.

**In order to support this cadre of caregivers, the following strategies will be utilized:**

1. Increase outreach to caregivers in order to raise public awareness regarding the importance of caregiver well-being and the role of caregivers in long term services and supports.
2. Increase number of caregivers accessing services and supports and participating in training to better maintain health and well-being and help to continue in caregiving role.



3. Increase the capacity of respite programs including volunteer respite programs.
4. Support infrastructure for providing Information & Referral (I&R) in telephonic and electronic formats to elders and families.

The following initiatives, with associated measures to track progress, will be used to support goal #3 strategies:

- Develop family caregiver support program web-page on 1-800-ageinfo and increase information access to professionals assisting and supporting caregivers and care recipients by conducting a statewide outreach campaign.
  - ✓ Metric ~ Number of I&R contacts for `family caregiver` on a quarterly basis.
  - ✓ Process Milestones ~ Convene workgroup, assess current outreach, identify target groups, develop campaign plan and track referrals. This work is ongoing.
- Coordinate the delivery of Powerful Tools training to build program capacity and increase consumer access.
  - ✓ Metrics ~ Increase number of caregivers taking Powerful Tools training by 20% with FY13 as baseline. Performance targets for out years to be determined.
- Verify that ADRC and I&R staff are fully versed in caregiver support strategies and services and ensure consumer use of Alzheimer's Association training for caregivers.
  - ✓ Process Milestone ~ Collaborate with Alzheimer's Association to conduct training for ADRC staff biannually.
- Build volunteer respite capacity.
  - ✓ Process Milestone ~ Partner with local Family Caregiver Support programs and MA Lifespan Respite Coalition to identify best practices in program design and management, working together to build infrastructure to support a volunteer corps.
- Seek and use grant funding and other strategies to provide additional capacity of respite services to reach more caregivers via FCSP and ASAP respite only programs.
  - ✓ Metrics ~ Increase by 10% the number of individuals utilizing respite services through FCSP or Elder Home Care programs with FY13 as baseline. Performance targets for out years to be determined.
- Ensure quality through training staff and auditing provider compliance with I&R contract requirements.



- ✓ Process Milestone ~ Report summary findings from quality assurance surveys on a monthly basis.

<b>Goal #4 – Protect and promote the well-being and quality of life of elders in the settings of their choice (community-based, facility-based, or healthcare settings).</b>
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Quality of life is affected in all settings by an individual's ability to be in control of his/her own life decisions and to be free from negative outside influences assuring support for freedom from external pressures. In addition, for those elders who are subject to abuse, neglect or financial exploitation from others as well as those who are self-neglecting in some way, protections must be available.

**The strategies to provide the protection of those most vulnerable in the Commonwealth and to be sure that support is available to prevent such exploitation include:**

1. Quality improvements in nursing facilities.
2. Review and enhance the Long Term Care, Assisted Living and Community Care Ombudsman programs.
3. Strengthen the Protective Services program.
4. Expand awareness of end of life issues and resources.

To support the strategies associated with Goal #4, the following initiatives with measures to track progress are presented:

- Issue payments for Pay for Performance (P4P) consistent assignment in nursing facilities contingent on state appropriation.
  - ✓ Process Milestones ~ Applications in and approved; send out P4P payments; complete 40 site audits; and confirm industry-wide compliance annually.
- Implement recommendation identified in the legislatively mandated MA Ombudsman Study completed by EOEA and released in April 2013.
  - ✓ Metric ~ Increase awareness of availability of Ombudsman among all MA residents. This work is ongoing.
  - ✓ Metric ~ Produce “Senior Scene” series for cable access about EOEA Ombudsman programs to educate and inform MA residents.
- Long Term Care Ombudsman program will continue working towards 100% weekly coverage of all nursing, and board and care facilities.



- ✓ Metrics ~ Number of nursing home resident contacts; percent of complaints of residents in long term care facilities investigated; and percent of residents in long term care facilities satisfied with investigation outcomes – on a quarterly basis.
- Assisted Living Ombudsman program will complete non-complaint visits to all (212) Assisted Living Residences.
  - ✓ Process Milestone ~ Based on findings from the initial non-complaint site visits, develop a schedule for ongoing non-complaint visits using priority criteria identified in the initial visits.
- Convene a multi-disciplinary team to reconsider how to improve the PS programs financial exploitation investigations.
  - ✓ Metrics ~ Number of PS investigations completed on a quarterly basis; Average length of service termination for substantiated cases of financial exploitation (Target 115 days) on an annual basis; and Percent of financial exploitation cases with reduced level of risk at time of disposition on a quarterly basis.
- Expand dissemination and use of Medical Orders for Life-Sustaining Treatment (MOLST) and other end of life documents.
  - ✓ Metrics ~ Not less than one clinical staff member trained in 50% of hospitals and nursing facilities using MOLST by December 31, 2014.
- Coordinate with DPH to integrate MOLST with Palliative and End of Life care.

**Goal #5 – Strengthen housing-with-supports options that support people living in the community and address the needs of people transitioning out of facility-based settings.**

Without safe and affordable housing options that allow for support services, many individuals would not be able to attain or maintain community living. Models that integrate housing with services that are flexible enough to adapt as housing and service needs change are most desirable.

**Strategies to achieve this type of housing with supports include:**

1. Establish new supportive housing sites.
2. Review assisted living regulations to address growth and demand.
3. Work with DTA and DPH to review board and care facilities.



Support of Goal #5 strategies are tracked by the following initiatives with measures:

- Build proposal to establish ten new supportive housing sites.
  - ✓ Process Milestone ~ Gain support of Department of Housing and Community Development (DHCD) for this expansion ongoing through State Plan period.
- Measure success of Supportive Housing model for maintaining individuals in their community settings.
  - ✓ Metrics ~ Percent of Supportive Housing residents receiving service coordination who are NF eligible; percent of NF eligible residents who extend residency in Supportive Housing at least 12 months after NF eligibility determination – measured on a quarterly basis.
- Perform review of Assisted Living regulations with special emphasis on special care units.
  - ✓ Process Milestones ~ Ongoing review of all sections of the Assisted Living regulations with proposals for changes completed by July 1, 2014.
- Conduct an analysis of Board and Care facilities in FY' 14.
  - ✓ Process Milestone ~ Assemble team (DTA, DPH, EOEA) to adopt a strategy pertaining to board and care facilities. This is ongoing.

**Goal #6 – Attain and sustain the best possible physical, cognitive, and mental health and the opportunity to benefit from proven methods for maximizing and improving one's abilities, health and happiness.**

The Aging Agenda asserts that as individuals grow older, there are elements that are within each person's immediate control that could have beneficial outcomes for a healthier and happier life.

**Some of the strategies we will use to move forward on this goal include:**

1. Increase access to CDSME programs for individuals across the state.
2. Increase the average daily census of participants at congregate meal sites.
3. Improve access to services for elders with mental health, substance abuse, Alzheimer's and dementia issues.
4. Encourage utilization of senior centers for maximal life satisfaction.



5. Promote healthy lifestyles, behaviors and strategies to prevent falls and fall-related injuries among older adults and people with disabilities.

Supporting Goal #6 strategies include the following initiatives with measures to track progress:

- Establish statewide infrastructure for CDSME programs; establish CDSME program intersection with medical/health care practices across state.
  - ✓ Process Milestone ~ Develop a minimum of 25 partnership agreements with agencies that can reach large numbers of people. This is ongoing.
  - ✓ Metric ~ Number of CDSME participant who complete the course per year over 3 year grant – our target is 1575 (completers are participants who complete 4 of 6 training sessions)
- Increase outreach, provide nutrition counseling, serve culturally appropriate meals and consider offering evening meals.
  - ✓ Metric ~ Average number of attendees per day at congregate meal sites on a quarterly basis.
  - ✓ Metric ~ Increase average daily census of participants at congregate meal sites by 2% with FY13 as baseline.
  - ✓ Process Milestone ~ Evaluate possibility of evening meals (pilot) – ongoing.
- Implement MA Alzheimer’s Disease and Related Disorders State Plan recommendation – Alzheimer’s Early Detection Alliance (AEDA) in partnership with MA Human Resources Division (HRD).
  - ✓ Process Milestones ~ Commonwealth enrolls as employer by July 15, 2013; Continue to enroll private employers – target 30 per year over the next 2 years.
- In the Home Care programs, screen elders for depression, substance abuse, Alzheimer’s and dementia.
  - ✓ Metrics ~ Number of Home Care consumers screened for depression, substance abuse, Alzheimer’s and dementia on a quarterly basis.
- Through the service incentive grants for COAs, support COA/senior centers who seek national accreditation.
  - ✓ Process Milestone ~ Increase by three per year the number of COA/senior centers that achieve accreditation.
- EOEA I&R staff to serve on Commission on Falls Prevention within the Department of Public Health.





- ✓ Process Milestone ~ Complete comprehensive study on how to prevent or mitigate falls by older adults and people with disabilities by the end of FY14.

### **Goal #7 - Develop operational improvements that provide better service, quality and efficiency**

Without an appropriate infrastructure to support the work necessary to achieve the goals outlined above, very few of them could be achieved.

**In order to achieve Goal #7 outcomes, the following strategies will be used:**

1. Build capacity to measure consumer outcomes of home care consumers and their family caregivers.
2. Establish capacity for physicians to view information on the long term services and supports of their patients.
3. Provide oversight and monitoring of ASAP operations through the ASAP designation review process
4. Monitor the quality of long term services and supports providers.
5. Increase ability of ADRC core members to make cross referrals through data sharing.

To support Goal #7 strategies, the following initiatives with measures will track progress:

- Collaboration with UMMS on data analytics.
  - ✓ Process Milestone ~ In FY13 and ongoing, analyze data to help develop policy that will improve consumer outcomes.
- Add Physicians Portal to SIMS.
  - ✓ Process Milestone ~ Provider access additions to Portal . This is ongoing.
- EOEa on-site review visits to ASAPs on a three year cycle.
  - ✓ Process Milestone ~ Complete nine ASAP designations.
- Implement use of a standard consumer satisfaction survey for ASAPs.
  - ✓ Process Milestones ~ Construct survey online and issue instructions to ASAPs on how to use the survey system and tools. This is ongoing.



- Enhance the ASAP/ILC IT systems to coordinate cross referrals for options counseling services.
  - ✓ Process Milestones ~ Develop capacity to track OC referrals and facilitate cross-referrals through “cloud-based” technology solution to interface the two data systems used by ASAPs and ILCs. This is ongoing.



## **Quality Management**

EOEA's quality management strategy is designed to assure that essential safeguards are met with respect to health, safety and quality of life for EOEA consumers. EOEA has active quality management systems for promoting and monitoring internal as well as external quality across the agency and the elder service network. For the network, quality is measured by a set of outcome measures, based on EOEA's mission statement, CMS assurances, performance measures as approved in the FEW, Commonwealth of Massachusetts' regulations, and AAA/ASAP quality oversight activities. The use of data and related information is necessary to monitor quality and promote ongoing quality improvement efforts. While there are multiple approaches in place to allow for a robust system, the overall quality management and improvement system continues to evolve and improve.

The ASAPs that contract with EOEA are responsible for assessing clinical eligibility, determining level of care, conducting needs assessments, developing and monitoring person-centered service plans, providing interdisciplinary case management, and reporting participant data to EOEA.

The seven strategies that guide the current Quality Management and Improvement System (QMIS) are the following:

1. Quality is approached from three levels: the individual, the provider and the overall system.
2. It begins with a thorough, person centered approach to service planning.
3. The system is designed to create a continuous loop of quality including identification of issues, notification to concerned parties, correction, follow-up, analysis of patterns and trends, and service improvement activities.
4. The system is designed to create a continuous presence with individuals and providers.
5. The system involves active participation from individuals, families, and other key stakeholders.
6. The system measures health and safety for participants and places a strong emphasis on the welfare of individual participants.
7. The system collects, aggregates, and analyzes data to identify patterns and trends to inform system improvement activities.

## **Internal Quality Management**

In a shared management effort to observe, monitor and adjust toward continuous improvement, thereby ensuring good outcomes in programs and management performance, EOEA program managers, on a periodic basis will share their data and analysis with supervisors prior to posting data to EHS Results (an online reporting tool for performance management at EOHHS). The



meetings present opportunities to assess what program procedures, policies or resources may need to be modified in order to improve program performance. Managers will also engage in a similar review of performance data analysis with their respective provider networks.

Beginning in Q3 of CY 2013, and continuing through the life of the State Plan, the Secretary of EOEa and the leadership team will convene quarterly performance management meetings. Managers will be scheduled to share a program summary report on their program goals, strategies, outcome data and analysis. In this manner, all managers and senior staff will have the opportunity to participate in program reviews, analyze provider performance, and contribute to the development of solutions to performance barriers. As a result of these new procedures, managers will utilize increased skills and additional tools for better management to improve agency culture to shift its focus from inputs to outcomes.



## **Attachment A – State Plan Assurances and Required Activities**

*The Secretary of the Executive Office of Elder Affairs, as the official signatory for the Massachusetts State Unit on Aging, hereby commits to performing all listed assurances and activities as stipulated in the Older Americans Act, as amended in 2006.*

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### **ASSURANCES**

#### **Sec. 305(a) - (c), ORGANIZATION**

(a)(2)(A) The State agency shall, except as provided in subsection (b)(5), designate for each such area (planning and service area) after consideration of the views offered by the unit or units of general purpose local government in such area, a public or private nonprofit agency or organization as the area agency on aging for such area.

(a)(2)(B) The State agency shall provide assurances, satisfactory to the Assistant Secretary, that the State agency will take into account, in connection with matters of general policy arising in the development and administration of the State plan for any fiscal year, the views of recipients of supportive services or nutrition services, or individuals using multipurpose senior centers provided under such plan.

(a)(2)(E) The State agency shall provide assurance that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;

(a)(2)(F) The State agency shall provide assurances that the State agency will require use of outreach efforts described in section 307(a)(16).

(a)(2)(G)(ii) The State agency shall provide an assurance that the State agency will undertake specific program development, advocacy, and outreach efforts focused on the needs of low-income minority older individuals and older individuals residing in rural areas.

(c)(5) In the case of a State specified in subsection (b)(5), the State agency and area agencies shall provide assurance, determined adequate by the State agency, that the area agency on aging will have the ability to develop an area plan and to carry out, directly or through contractual or other arrangements, a program in accordance with the plan within the planning and service area.



***The Massachusetts Executive Office of Elder Affairs declares that the following assurances (Section 306) will be incorporated into the 2014-2017 Area Plans on Aging, and thus be revealed as required affirmations by the twenty-three designated Area Agencies on Aging in Massachusetts.***

### **Sec. 306(a), AREA PLANS**

(2) Each area agency on aging shall provide assurances that an adequate proportion, as required under section 307(a)(2), of the amount allotted for part B to the planning and service area will be expended for the delivery of each of the following categories of services-

(A) services associated with access to services (transportation, health services (including mental health services), outreach, information and assistance (which may include information and assistance to consumers on availability of services under part B and how to receive benefits under and participate in publicly supported programs for which the consumer may be eligible), and case management services);

(B) in-home services, including supportive services for families of older individuals who are victims of Alzheimer's disease and related disorders with neurological and organic brain dysfunction; and

(C) legal assistance; and assurances that the area agency on aging will report annually to the State agency in detail the amount of funds expended for each such category during the fiscal year most recently concluded.

(4)(A)(i)(I) provide assurances that the area agency on aging will—

(aa) set specific objectives, consistent with State policy, for providing services to older individuals with greatest economic need, older individuals with greatest social need, and older individuals at risk for institutional placement;

(bb) include specific objectives for providing services to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas; and  
(II) include proposed methods to achieve the objectives described in items (aa) and (bb) of subclause (I);

(ii) provide assurances that the area agency on aging will include in each agreement made with a provider of any service under this title, a requirement that such provider will—

(I) specify how the provider intends to satisfy the service needs of low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in the area served by the provider;

(II) to the maximum extent feasible, provide services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas in accordance with their need for such services; and

(III) meet specific objectives established by the area agency on aging, for providing services to low-income minority individuals, older individuals with limited English proficiency, and older individuals residing in rural areas within the planning and service area; and

(4)(A)(iii) With respect to the fiscal year preceding the fiscal year for which such plan is prepared, each area agency on aging shall—



(I) identify the number of low-income minority older individuals and older individuals residing in rural areas in the planning and service area;

(II) describe the methods used to satisfy the service needs of such minority older individuals; and

(III) provide information on the extent to which the area agency on aging met the objectives described in clause (a)(4)(A)(i).

(4)(B)(i) Each area agency on aging shall provide assurances that the area agency on aging will use outreach efforts that will identify individuals eligible for assistance under this Act, with special emphasis on—

(I) older individuals residing in rural areas;

(II) older individuals with greatest economic need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(III) older individuals with greatest social need (with particular attention to low-income minority individuals and older individuals residing in rural areas);

(IV) older individuals with severe disabilities;

(V) older individuals with limited English proficiency;

(VI) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(VII) older individuals at risk for institutional placement; and

(4)(C) Each area agency on agency shall provide assurance that the area agency on aging will ensure that each activity undertaken by the agency, including planning, advocacy, and systems development, will include a focus on the needs of low-income minority older individuals and older individuals residing in rural areas.

(5) Each area agency on aging shall provide assurances that the area agency on aging will coordinate planning, identification, assessment of needs, and provision of services for older individuals with disabilities, with particular attention to individuals with severe disabilities, and individuals at risk for institutional placement, with agencies that develop or provide services for individuals with disabilities.

(6)(F) Each area agency will:

in coordination with the State agency and with the State agency responsible for mental health services, increase public awareness of mental health disorders, remove barriers to diagnosis and treatment, and coordinate mental health services (including mental health screenings) provided with funds expended by the area agency on aging with mental health services provided by community health centers and by other public agencies and nonprofit private organizations;

(9) Each area agency on aging shall provide assurances that the area agency on aging, in carrying out the State Long-Term Care Ombudsman program under section 307(a)(9), will expend not less than the total amount of funds appropriated under this Act and expended by the agency in fiscal year 2000 in carrying out such a program under this title.





(11) Each area agency on aging shall provide information and assurances concerning services to older individuals who are Native Americans (referred to in this paragraph as "older Native Americans"), including-

(A) information concerning whether there is a significant population of older Native Americans in the planning and service area and if so, an assurance that the area agency on aging will pursue activities, including outreach, to increase access of those older Native Americans to programs and benefits provided under this title;

(B) an assurance that the area agency on aging will, to the maximum extent practicable, coordinate the services the agency provides under this title with services provided under title VI; and

(C) an assurance that the area agency on aging will make services under the area plan available, to the same extent as such services are available to older individuals within the planning and service area, to older Native Americans.

(13)(A) Each area agency on aging shall provide assurances that the area agency on aging will maintain the integrity and public purpose of services provided, and service providers, under this title in all contractual and commercial relationships.

(13)(B) Each area agency on aging shall provide assurances that the area agency on aging will disclose to the Assistant Secretary and the State agency--

(i) the identity of each nongovernmental entity with which such agency has a contract or commercial relationship relating to providing any service to older individuals; and

(ii) the nature of such contract or such relationship.

(13)(C) Each area agency on aging shall provide assurances that the area agency will demonstrate that a loss or diminution in the quantity or quality of the services provided, or to be provided, under this title by such agency has not resulted and will not result from such non-governmental contracts or such commercial relationships.

(13)(D) Each area agency on aging shall provide assurances that the area agency will demonstrate that the quantity or quality of the services to be provided under this title by such agency will be enhanced as a result of such non-governmental contracts or commercial relationships.

(13)(E) Each area agency on aging shall provide assurances that the area agency will, on the request of the Assistant Secretary or the State, for the purpose of monitoring compliance with this Act (including conducting an audit), disclose all sources and expenditures of funds such agency receives or expends to provide services to older individuals.

(14) Each area agency on aging shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(15) provide assurances that funds received under this title will be used-

(A) to provide benefits and services to older individuals, giving priority to older individuals identified in paragraph (4)(A)(i); and



(B) in compliance with the assurances specified in paragraph (13) and the limitations specified in section 212;

(17) Each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.

### **Sec. 307, STATE PLANS**

(7)(A) The plan shall provide satisfactory assurance that such fiscal control and fund accounting procedures will be adopted as may be necessary to assure proper disbursement of, and accounting for, Federal funds paid under this title to the State, including any such funds paid to the recipients of a grant or contract.

(7)(B) The plan shall provide assurances that--

(i) no individual (appointed or otherwise) involved in the designation of the State agency or an area agency on aging, or in the designation of the head of any subdivision of the State agency or of an area agency on aging, is subject to a conflict of interest prohibited under this Act;

(ii) no officer, employee, or other representative of the State agency or an area agency on aging is subject to a conflict of interest prohibited under this Act; and

(iii) mechanisms are in place to identify and remove conflicts of interest prohibited under this Act.

(9) The plan shall provide assurances that the State agency will carry out, through the Office of the State Long-Term Care Ombudsman, a State Long-Term Care Ombudsman program in accordance with section 712 and this title, and will expend for such purpose an amount that is not less than an amount expended by the State agency with funds received under this title for fiscal year 2000, and an amount that is not less than the amount expended by the State agency with funds received under title VII for fiscal year 2000.

(10) The plan shall provide assurance that the special needs of older individuals residing in rural areas will be taken into consideration and shall describe how those needs have been met and describe how funds have been allocated to meet those needs.

(11)(A) The plan shall provide assurances that area agencies on aging will--

(i) enter into contracts with providers of legal assistance which can demonstrate the experience or capacity to deliver legal assistance;

(ii) include in any such contract provisions to assure that any recipient of funds under division (A) will be subject to specific restrictions and regulations promulgated under the Legal Services Corporation Act (other than restrictions and regulations governing eligibility for legal assistance under such Act and governing membership of local governing boards) as determined appropriate by the Assistant Secretary; and

(iii) attempt to involve the private bar in legal assistance activities authorized under this title, including groups within the private bar furnishing services to older individuals on a pro bono and reduced fee basis.



(11)(B) The plan contains assurances that no legal assistance will be furnished unless the grantee administers a program designed to provide legal assistance to older individuals with social or economic need and has agreed, if the grantee is not a Legal Services Corporation project grantee, to coordinate its services with existing Legal Services Corporation projects in the planning and service area in order to concentrate the use of funds provided under this title on individuals with the greatest such need; and the area agency on aging makes a finding, after assessment, pursuant to standards for service promulgated by the Assistant Secretary, that any grantee selected is the entity best able to provide the particular services.

(11)(D) The plan contains assurances, to the extent practicable, that legal assistance furnished under the plan will be in addition to any legal assistance for older individuals being furnished with funds from sources other than this Act and that reasonable efforts will be made to maintain existing levels of legal assistance for older individuals;

(11)(E) The plan contains assurances that area agencies on aging will give priority to legal assistance related to income, health care, long-term care, nutrition, housing, utilities, protective services, defense of guardianship, abuse, neglect, and age discrimination.

(12) The plan shall provide, whenever the State desires to provide for a fiscal year for services for the prevention of abuse of older individuals, the plan contains assurances that any area agency on aging carrying out such services will conduct a program consistent with relevant State law and coordinated with existing State adult protective service activities for--

(A) public education to identify and prevent abuse of older individuals;

(B) receipt of reports of abuse of older individuals;

(C) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance where appropriate and consented to by the parties to be referred; and

(D) referral of complaints to law enforcement or public protective service agencies where appropriate.

(13) The plan shall provide assurances that each State will assign personnel (one of whom shall be known as a legal assistance developer) to provide State leadership in developing legal assistance programs for older individuals throughout the State.

(15) The plan shall provide assurances that, if a substantial number of the older individuals residing in any planning and service area in the State are of limited English-speaking ability, then the State will require the area agency on aging for each such planning and service area—

(A) to utilize in the delivery of outreach services under section 306(a)(2)(A), the services of workers who are fluent in the language spoken by a predominant number of such older individuals who are of limited English-speaking ability; and

(B) to designate an individual employed by the area agency on aging, or available to such area agency on aging on a full-time basis, whose responsibilities will include--



(i) taking such action as may be appropriate to assure that counseling assistance is made available to such older individuals who are of limited English-speaking ability in order to assist such older individuals in participating in programs and receiving assistance under this Act; and

(ii) providing guidance to individuals engaged in the delivery of supportive services under the area plan involved to enable such individuals to be aware of cultural sensitivities and to take into account effectively linguistic and cultural differences.

(16) The plan shall provide assurances that the State agency will require outreach efforts that will—

(A) identify individuals eligible for assistance under this Act, with special emphasis on—

(i) older individuals residing in rural areas;

(ii) older individuals with greatest economic need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iii) older individuals with greatest social need (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas;

(iv) older individuals with severe disabilities;

(v) older individuals with limited English-speaking ability; and

(vi) older individuals with Alzheimer's disease and related disorders with neurological and organic brain dysfunction (and the caretakers of such individuals); and

(B) inform the older individuals referred to in clauses (i) through (vi) of subparagraph (A), and the caretakers of such individuals, of the availability of such assistance.

(17) The plan shall provide, with respect to the needs of older individuals with severe disabilities, assurances that the State will coordinate planning, identification, assessment of needs, and service for older individuals with disabilities with particular attention to individuals with severe disabilities with the State agencies with primary responsibility for individuals with disabilities, including severe disabilities, to enhance services and develop collaborative programs, where appropriate, to meet the needs of older individuals with disabilities.

(18) The plan shall provide assurances that area agencies on aging will conduct efforts to facilitate the coordination of community-based, long-term care services, pursuant to section 306(a)(7), for older individuals who--

(A) reside at home and are at risk of institutionalization because of limitations on their ability to function independently;

(B) are patients in hospitals and are at risk of prolonged institutionalization; or

(C) are patients in long-term care facilities, but who can return to their homes if community-based services are provided to them.

(19) The plan shall include the assurances and description required by section 705(a).



(20) The plan shall provide assurances that special efforts will be made to provide technical assistance to minority providers of services.

(21) The plan shall

(A) provide an assurance that the State agency will coordinate programs under this title and programs under title VI, if applicable; and

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title, if applicable, and specify the ways in which the State agency intends to implement the activities.

(22) If case management services are offered to provide access to supportive services, the plan shall provide that the State agency shall ensure compliance with the requirements specified in section 306(a)(8).

(23) The plan shall provide assurances that demonstrable efforts will be made--

(A) to coordinate services provided under this Act with other State services that benefit older individuals; and

(B) to provide multigenerational activities, such as opportunities for older individuals to serve as mentors or advisers in child care, youth day care, educational assistance, at-risk youth intervention, juvenile delinquency treatment, and family support programs.

(24) The plan shall provide assurances that the State will coordinate public services within the State to assist older individuals to obtain transportation services associated with access to services provided under this title, to services under title VI, to comprehensive counseling services, and to legal assistance.

(25) The plan shall include assurances that the State has in effect a mechanism to provide for quality in the provision of in-home services under this title.

(26) The plan shall provide assurances that funds received under this title will not be used to pay any part of a cost (including an administrative cost) incurred by the State agency or an area agency on aging to carry out a contract or commercial relationship that is not carried out to implement this title.

(27) The plan shall provide assurances that area agencies on aging will provide, to the extent feasible, for the furnishing of services under this Act, consistent with self-directed care.

### **Sec. 308, PLANNING, COORDINATION, EVALUATION, AND ADMINISTRATION OF STATE PLANS**

(b)(3)(E) No application by a State under subparagraph (b)(3)(A) shall be approved unless it contains assurances that no amounts received by the State under this paragraph will be used to hire any individual to fill a job opening created by the action of the State in laying off or terminating the employment of any regular employee not supported under this Act in anticipation of filling the vacancy so created by hiring an employee to be supported through use of amounts received under this paragraph.



## **Sec. 705, ADDITIONAL STATE PLAN REQUIREMENTS (as numbered in statute)**

(1) The State plan shall provide an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter.

(2) The State plan shall provide an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle.

(3) The State plan shall provide an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights.

(4) The State plan shall provide an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter.

(5) The State plan shall provide an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5).

(6) The State plan shall provide an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—

(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for--

(i) public education to identify and prevent elder abuse;

(ii) receipt of reports of elder abuse;

(iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and

(iv) referral of complaints to law enforcement or public protective service agencies if appropriate;

(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and

(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except--

(i) if all parties to such complaint consent in writing to the release of such information;

(ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or

(iii) upon court order



## REQUIRED ACTIVITIES

### Sec. 307(a) STATE PLANS

(1)(A) The State Agency requires each area agency on aging designated under section 305(a)(2)(A) to develop and submit to the State agency for approval, in accordance with a uniform format developed by the State agency, an area plan meeting the requirements of section 306; and

(B) The State plan is based on such area plans.

(2) The State agency:

(A) evaluates, using uniform procedures described in section 202(a)(26), the need for supportive services (including legal assistance pursuant to 307(a)(11), information and assistance, and transportation services), nutrition services, and multipurpose senior centers within the State;

(B) has developed a standardized process to determine the extent to which public or private programs and resources (including Department of Labor Senior Community Service Employment Program participants, and programs and services of voluntary organizations) have the capacity and actually meet such need;

(4) The plan shall provide that the State agency will conduct periodic evaluations of, and public hearings on, activities and projects carried out in the State under this title and title VII, including evaluations of the effectiveness of services provided to individuals with greatest economic need, greatest social need, or disabilities (with particular attention to low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas). Note: Periodic (defined in 45CFR Part 1321.3) means, at a minimum, once each fiscal year.

(5) The State agency:

(A) affords an opportunity for a public hearing upon request, in accordance with published procedures, to any area agency on aging submitting a plan under this title, to any provider of (or applicant to provide) services;

(B) issues guidelines applicable to grievance procedures required by section 306(a)(10); and

(C) affords an opportunity for a public hearing, upon request, by an area agency on aging, by a provider of (or applicant to provide) services, or by any recipient of services under this title regarding any waiver request, including those under Section 316.

(6) The State agency will make such reports, in such form, and containing such information, as the Assistant Secretary may require, and comply with such requirements as the Assistant Secretary may impose to insure the correctness of such reports.

(8)(A) No supportive services, nutrition services, or in-home services are directly provided by the State agency or an area agency on aging in the State, unless, in the judgment of the State agency--

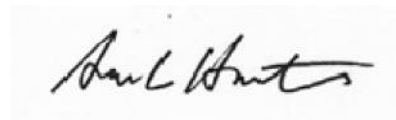
(i) provision of such services by the State agency or the area agency on aging is necessary to assure an adequate supply of such services;





(ii) such services are directly related to such State agency's or area agency on aging's administrative functions; or

(iii) such services can be provided more economically, and with comparable quality, by such State agency or area agency on aging.



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Ann L. Hartstein, Secretary

July 1, 2013

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Date

Executive Office of Elder Affairs  
Commonwealth of Massachusetts



## **Attachment B – State Plan Information Requirements**

*The Secretary of the Executive Office of Elder Affairs, as the official signatory for the Massachusetts State Unit on Aging, hereby provides the following responses in support of each Older Americans Act citation as listed below.*

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### **INFORMATION REQUIREMENTS**

#### **Section 305(a)(2)(E)**

*Describe the mechanism(s) for assuring that preference will be given to providing services to older individuals with greatest economic need and older individuals with greatest social need, (with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and older individuals residing in rural areas) and include proposed methods of carrying out the preference in the State plan;*

The Executive Office of Elder Affairs (EOEA) preserves the Older Americans Act (OAA) mandate that funding be made available for the provision of services to persons sixty (60) years of age or older with preference in service delivery to older persons in greatest social or economic need, with particular attention to older individuals with limited English proficiency, and elders living in rural areas. As the central mechanism in support of serving elders targeted under the OAA, EOEA bases 82.5% of the Intrastate Funding Formula on components that address isolated (live alone and rural) elders (20%), low income elders (47.5%), and minority elders (20%). This decision enables the targeting of Title III funding to elder populations across the state that are most in need of support.

A second tool used to focus services on elders with greatest economic and greatest social need is the use of diverse outreach methods. EOEA and the AAAs have taken great care to generate outreach and participation opportunities for OAA targeted populations through the mandated four-year Needs Assessment Project, as well as annually throughout the duration of the State Plan period. Each AAA uses its unique personality to reach isolated elders. Television/cable, radio, and newspaper media are used as outreach mechanisms in several of the larger Planning and Service Areas (PSA) where face-to-face connections are challenging. AAAs with more concentrated PSAs will use personal contact through Councils on Aging, congregate meal sites and housing facilities. AAAs use any number of methods to reach out to elders in isolation and those elders with greatest economic need.

Additionally, as EOEA and the AAAs reach out to targeted populations, we are committed to providing culturally competent services. By addressing limited English proficiency (LEP) consumers with bi-lingual providers, offering interpreters, and translated written materials the network ensures that services are available to all elders. Outreach to socially isolated populations, including Native Americans, LEP consumers, and LGBT elders, through trainings, listening sessions, and sponsored events helps the AAAs connect to the populations in need



of support and assistance. Furthermore, as conveyed below under Section (307(a)(3), outreach to rural elders remains a concerted effort for those AAAs with isolated, rural populations; especially PSAs in the western part of the State, and to a lesser degree in central Massachusetts.

As identified in the OAA and pertinent regulations, the twenty-three AAAs, and their providers, are cognizant of the policy that Title III services are to be provided without use of any means test. Through policy review, assessment of collection practices, and monitoring procedures, EOEA and the AAAs reinforce the rules on voluntary contributions. The network is made aware of the regulations on this matter and AAAs and providers do not means test for any service under Title III or deny services to any individual who does not contribute to the cost of the service.

### **Section 306(a)(17)**

*Describe the mechanism(s) for assuring that each Area Plan will include information detailing how the Area Agency will coordinate activities and develop long-range emergency preparedness plans with local and State emergency response agencies, relief organizations, local and State governments and other institutions that have responsibility for disaster relief service delivery.*

Each of the 23 AAAs in Massachusetts is required to complete and implement plans that address activities for long-range emergency preparedness within their Area Plans on Aging, 2014-2017 (AAA Plans). AAAs communicate plans, activities, and collaborations that address the unique circumstances for emergency planning in the PSA they serve. As a vital participant within the community, each AAA shoulders responsibility in preparing policies and procedures for implementation during an emergency. Plans ensure that communications regarding preparation for emergency management are shared with the community, while realistic expectations regarding the agency's role and capacity are considered. AAAs, according to their respective plans, establish and maintain relationships with local or regional emergency personnel such as police, fire, hospitals, and the American Red Cross, and ensure evacuation plans are reviewed and updated annually.

Additionally, AAA Plans focus on emergency preparedness on a more micro level with a review of procedures in place for more conventional disruptions. AAAs collaborate with COAs, senior centers and other organizations that provide Title III services to plan for, establish priorities under and implement emergency strategies. AAAs and their providers, including COAs, are required to review, evaluate and modify practices, as needed, in the context of short-term daily crises, including fire drills, building access issues, heating/cooling system malfunctions, temporary building relocations, and any other misfortune that suspends services to elders on a short-term basis. While this effort is more routine in nature, well developed and planned responses to crises, regardless of the magnitude, are key to the continuation of services to and the well-being of elders and caregivers.

Shared responsibility is essential in developing sound emergency preparedness plans, (also see response to Section 307(a)(29) below). With EOEA guidance, the elder network has joined efforts to prepare and communicate a statewide effort in



the face of disasters and emergencies. Each AAA/ASAP is required to have in place a Continuity of Operations Plan (COOP) which details the policies and procedures for implementation during an emergency. In connection with requirements as detailed in the Older Americans Act, emergency management plans for frail and homebound elder consumers, vendor communications, and service restorations are required as part of the AAA Plans. Agency closures, delayed starts, cancelled meals, service interruptions, protective issues and other emergency situations (snowstorm, ice storm, hurricane, water main break, flooding, electrical issues, phone issues etc.) are examples of disaster situations where a COOP plan would be launched by the AAA/ASAP to provide disaster relief service delivery.

The distinct elements of COOP plans vary across all twenty-three AAAs based on any number of factors including, geographical setting, size of at-risk populations, volunteer capacity, strength of community partnerships, and communication promotion and infrastructure. The State Unit on Aging has established procedures for AAAs to follow in the event of agency closings, delayed starts, service interruptions, and similar events associated with both temporary and long-term service interruptions. Communication links are established and maintained for emergencies for Home Care, Nutrition, Council on Aging, Protective, and I&R services. The teamwork between EOEA and the AAA/ASAPs is crucial to maintain communications and provide briefs for the Secretary of EOHHS, Governor's Office and/or the Administration for Community Living.

### **Section 307(a)(2)**

The plan shall provide that the State agency will:

(C) *Specify a minimum proportion of the funds received by each area agency on aging in the State to carry out part B that will be expended (in the absence of a waiver under sections 306 (c) or 316) by such area agency on aging to provide each of the categories of services specified in section 306(a)(2) (Note: those categories are access, in-home, and legal assistance). Provide specific minimum proportion determined for each category of service.*

As required under the Older Americans Act, Section 307 (a)(2)(C), EOEA has established a minimum proportion of the funding received by each Area Agency on Aging in the state under Part B of the Act, be mandated for the provision of certain priority services; access, in-home and legal services. As part of the annual monitoring review, EOEA confirms that each AAA meets the priority services requirements as assigned. The following indicates the minimum funding percentages for priority services.

Access Services	two (2) percent of Part B funding available.
In-home Services	two (2) percent of Part B funding available.
Legal Services *	eight (8) percent of Part B funding available.

\* The legal services percentage is based on a minimum standard plus an individual maintenance of effort required separately of each AAA.



### **Section (307(a)(3)**

The plan shall: ...

(B) with respect to services for older individuals residing in rural areas:

(i) provide assurances the State agency will spend for each fiscal year of the plan, not less than the amount expended for such services for fiscal year 2000.

(ii) *identify, for each fiscal year to which the plan applies, the projected costs of providing such services (including the cost of providing access to such services).*

(iii) *describe the methods used to meet the needs for such services in the fiscal year preceding the first year to which such plan applies.*

EOEA, under the bounds of administering Title III funds through the Massachusetts Intrastate Funding Formula, defines rural as those communities with less than 100 persons per square mile. Based on this definition and according to Census 2010, the total population of rural elders, 60+, residing in 66 communities across the Commonwealth, totals 20,984; the number of rural elders who are 65+, totals 13,465 elders. Rural elders, 60+, represent 1.65% of the total elders in Massachusetts.

In addition to our continuing assurance to address the unique needs of rural elders in Massachusetts, EOEA remains committed to working with the appropriate AAAs in identifying and serving persons that reside in rural communities. The networks efforts on this strategy are supported within the Massachusetts Intrastate Funding Formula – comprised of six basic components that are weighted relative to the significance of each component within the total formula – 5% of the Formula is assigned to the proportion of persons living in rural towns within the State. EOEA has a tradition of ensuring services for rural elder and intends to maintain and strengthen these resources for isolated elders.

In accordance with Administration on Aging directives, EOEA assures that expenditures for services to rural elders in the Commonwealth over the four year State Plan period will not be less than the amount expended for such services for fiscal year 2000. Based on prior State Plan submissions, the fiscal year 2000 base figure for rural elder expenditures is \$585,750.00. Based on 2012 data from the SIMS system, services to rural elders – using zip codes as the sorting factor – totaled more than \$1.2M in services, with the vast majority of those services under congregate and home delivered meals. Provided that current Title III funding trends hold constant, we are projecting for fiscal years 2014, 2015, 2016 and 2017 that expenditures for rural elders reach \$1.225M, \$1.250M, \$1.275M, and \$1.3M per year, respectively.

### **Section 307(a)(10)**

The plan shall provide assurance that the special needs of older individuals residing in rural areas are taken into consideration and shall *describe how those needs have been met and describe how funds have been allocated to meet those needs.*



The health and long-term care needs of rural elders are unique and are often more difficult to manage and less likely to be met given the possible limitations for health and social services in rural settings. There are many common traits that distinguish rural elders from their urban counterparts; including being in poorer health, having lower incomes – with a better chance of being poor, possessing less formal education, limited or reduced access to health care and social services – including adult day health and adult social day programs, and limited public transportation. Additionally, given the lack of transportation choices, rural elders are more likely to rely on family or friends for transportation or have a greater dependence on cars; creating additional problems if the ability to drive diminishes.

As part of the FY2013 Commonwealth Budget, a special commission was created to study access to public assistance and state-sponsored services in rural areas, the Massachusetts Rural Services Commission (RSC). The RSC is charged with examining the barriers faced by low-to moderate-income individuals living in rural areas to obtain public assistance and state-sponsored services including, but not limited to, fuel assistance, child care subsidies, direct cash assistance, emergency housing services and health and human service programs which provide services to children, families, persons with disabilities and elders. With input from various state, local and private organizations, the Commission is investigating the feasibility of coordinating delivery of services between local and state agencies, expanding the use of technology to increase access to services and eliminating application requirements for in-person visits to state agencies. The work of the Commission is currently underway and includes EOEa and Franklin County AAA/ASAP representation.

In promoting the special needs of rural elders, EOEa is also a member of the Commission for the Reform of Community, Social Service and Paratransit Transportation Services. Created through Patrick Administration Executive Order No. 530, the Commission is charged with conducting a comprehensive review of all state- and federally-funded community transportation services, including demand responsive services, paratransit services, ADA complementary paratransit service and social services transportation. The Commission membership includes EOEa representation, state transportation officials, regional transit authorities, local government representatives and consumers. The Commission recommended reforms, restructuring and cost-saving initiatives that would modify or alter the current means of providing paratransit services in the Commonwealth, including potential legislative solutions. As recommendations from the Commission continue to be studied, EOEa will use its participation on the RSC (above) to promote the transportation needs of elders, including those living in rural, isolated areas of the state.

As required by the OAA and in support of EOEa's mission to provide access to services for all elders 60+ and over, the elder network in Massachusetts' focus on rural elders helps to identify and provide services to geographically isolated elders. Seven of the 23 AAAs contain populations of elders defined as rural, that is, those areas containing less than one hundred persons per square mile. The



Massachusetts aging network holds a tradition of highlighting services for rural elders and current efforts will strengthen resources for isolated elders.

In support of EOE's efforts to focus resources and services on rural elders, the Massachusetts Intrastate Funding Formula assigns 5% of Title III funding to elders 65+ living in rural communities - those communities with less than 100 persons per square mile. Additionally, the seven AAAs containing rural populations have consistently maintained great efforts to reach out to and engage rural elders. The network works to engage isolated elders through outreach efforts and program planning that supports socialization and wellness activities, benefits counseling, including SHINE counseling, volunteer recruitment, and transportation services.

EOEA will continue to foster and encourage communication, coordination and partnerships that enable AAAs with rural elder populations to identify and provide services to isolated elders. AAAs with rural elder populations are directed to explain within their AAA Plans, approaches for addressing the unique needs of this population. Serving rural populations, as well as localities that are geographically isolated and difficult to serve, create barriers to access for elders. Solutions vary between AAAs, but the effort to develop unique solutions and reach isolated elders fulfills the commitment to serve older individuals residing in rural areas. Some of the common solutions include public forums, encouraging representation on AAA Advisory Councils, information and benefit fairs, targeted needs assessment and research endeavors, and mass media, newspaper and community service notices.

#### **Section 307(a)(14)**

(14) The plan shall, with respect to the fiscal year preceding the fiscal year for which such plan is prepared—

*(A) identify the number of low-income minority older individuals in the State, including the number of low income minority older individuals with limited English proficiency; and*

The following figures represent the Massachusetts 60+ elder population for each of the highlighted populations as extracted from the Census 2010 (Tables P12, P12A-P12I):

American Indian	2,076
Native Hawaiian	228
Asian	36,451
Black	52,055
Hispanic	43,194

Additional targeted demographic data of the Massachusetts 65+ elder population obtained from the American Community Survey (ACS) 5-Year Estimates, include:

Low-income Minority Elders (65+) (Below poverty level.)	16,902
Elders with Limited English Proficiency (65+) (Those 65+ who do not speak English well or not at all.)	5,418





(B) *describe the methods used to satisfy the service needs* of the low-income minority older individuals described in subparagraph (A), including the plan to meet the needs of low-income minority older individuals with limited English proficiency.

EOEA and the AAAs continue to advocate for and commit resources to those most vulnerable populations of elders residing in the Commonwealth. The elder network makes great effort to locate elders in greatest economic need, physically and socially isolated elders, while placing a particular importance on addressing the needs of low-income elders. The network has also targeted individuals with limited English proficiency (LEP) in an increased awareness as a targeted population. Targeting low income elders for programs and services is woven throughout the mission and efforts that identify elder services in Massachusetts.

**Title III Community-Based Programs:** The aging network continues a long history of committing the resources under the Title III programs to low-income and low-income minority elders. The Massachusetts Intrastate Funding Formula allocates a combined 67.5% of Title III funding to low-income and minority elders through allocations to the AAAs. Through the distribution of Title III-B Supportive Services, Title III-C Nutrition Services, Title III-D Preventive Health Services and Title III-E Family Caregiver Services, the aging network is directing services and programs to elders and their caregivers as targeted in the OAA.

**Elderly Nutrition Program:** Twenty-seven nutrition programs located throughout the state serve over eight and a half million meals to seniors each year. Meals are provided at more than 400 congregate meal sites and are delivered to frail elders in their homes. Nutrition services help to address a number of problems faced by many elders, including poor diets, health problems, food insecurity, financial constraints, and loneliness. Key nutrition services include nourishing meals, as well as nutrition screening, assessment, education, and counseling, to ensure that older people achieve and maintain optimal nutritional status.

As an enhancement to Section 305(a)(2)(E) addressed above and in highlighting State programs that address low-income elders, the following programs illustrate Massachusetts' effort:

**Circuit Breaker Tax Credit:** A state income tax credit for eligible Massachusetts residents age 65 or older who paid rent or real estate taxes during the tax year. Even though the credit is based on property taxes, the state government, not the city or town, pays the credit. The credit is for senior homeowners and renters who meet income limits and other eligibility requirements.

**MassHealth/EOEA Office of Long Term Care (OLTSS):** OLTSS is responsible for the development and oversight of MassHealth services that meet the needs of MassHealth members whose conditions and disabilities require long term supports. These services are available to eligible members of all ages, and are provided in a variety of home, community, and institutional settings. These programs are paid for by state appropriation and receive federal Title XIX funding.



OLTSS manages these programs through contracted networks of eligible providers. OLTSS manages the services, and the providers who supply them, by establishing programmatic and pricing regulations, and monitoring providers' compliance with those regulations. OLTSS also manages two capitated benefit plans that provide a full range of acute, behavioral, and long-term care services to enrolled elders. OLTSS is organized into three units: Community Services, Institutional, Residential, and Day Services, and Integrated Health Plans. OLTSS also includes a Clinical Unit, staffed by R.N.s who supports the management of the MassHealth programs as well as EOE's Home Care programs.

**Senior Community Service Employment Program:** A program funded under Title V of the OAA through the U.S. Department of Labor, enables EOE to help employ low-income individuals, age 55 and older, throughout the Commonwealth. Enrollees are placed in temporary training assignments where they gain valuable on-the-job work experience and training needed to gain employment in the private sector.

### **Section 307(a)(21)**

The plan shall:

(B) provide an assurance that the State agency will pursue activities to increase access by older individuals who are Native Americans to all aging programs and benefits provided by the agency, including programs and benefits provided under this title (*title III*), if applicable, *and specify the ways in which the State agency intends to implement the activities.*

A review of 2010 Census data reveals Native American/American Indian populations in each of the twenty-three AAAs, with a reported 60+ population across the Commonwealth totaling 2,076 individuals. While Native American elders are spread across the state, there are elevated concentrations in the southeast region of the state, Cape Cod and Islands, Boston (Jamaica Plain area), Merrimack Valley, and the cities of Springfield and Worcester. Historically, EOE has not been the recipient of OAA Title VI funding, however, the elder network as a whole accomplishes a high degree of outreach and service delivery to Native Americans.

AAAs with significant Native American populations are cognizant of and work to foster partnerships between mainstream entities and community-based organizations that have the established trust of this population, indicates the commitment of the network to address this challenge. The effort to deliver essential aging services and educate underserved, un-served and hard-to-reach Native American elders will continue throughout the life of the State Plan 2014-2017. Particular statewide efforts in addressing Native Americans needs include SHINE Program training methods that recognize American Indian/Alaska Native culture.

Recent AAA efforts to connect with tribal organizations include Title III grants for homemaking, transportation services, and companionship. AAA services planned for 2014 include efforts to include Native American elders through focused outreach, education and information sharing with Native American community



leaders, and sharing of opportunities under the Title III programs. In an effort to foster outreach and inclusion, EOEA will encourage AAAs to embrace tribal organizations and Native American elders through Advisory Council membership, Title III service award proposals, attentive service planning approaches, and culturally sensitive connections.

### **Section 307(a)(29)**

*The plan shall include information detailing how the State will coordinate activities, and develop long-range emergency preparedness plans, with area agencies on aging, local emergency response agencies, relief organizations, local governments, State agencies responsible for emergency preparedness, and any other institutions that have responsibility for disaster relief service delivery.*

The purpose of emergency preparedness management is to provide policy and guidance to ensure the continuance of essential functions during circumstances of serious staff reduction caused by extreme weather conditions, pandemic flu, and other disasters. Conditions that may lead to the activation of an Emergency Management Plan may include:

- Notification from the Department of Public Health (DPH) regarding a virus alert or pandemic event;
- Declaration of a state of emergency by the Governor.
- Notification by the Massachusetts Emergency Management Agency (MEMA) of an emergency situation.
- Local conditions at site or within region (weather, fire, flood, loss of electricity)

The development of effective emergency management requires the coordination and training of staff and service providers. A thorough planning process addresses the expectations and responsibilities of all groups involved. In the development of a Continuity of Operations Plan (COOP) and standard operating procedures (SOPs), EOEA defines how to ensure the safety of staff and carry on the essential job functions necessary to ensure the safety and well-being of the elders most in need of our assistance, especially during times of emergencies.

The purpose of a COOP is to provide guidance to all EOEA staff to ensure their safety and protection during an emergency as well as the continuance of essential agency functions in the event that our agency site is inaccessible due to an emergency. The essential functions of the COOP include:

1. Provider Notification – EOEA must ensure service providers are notified in a timely manner to activate their own COOPs to continue essential nutrition, home care, protective services, information and referral, and other basic services for frail and homebound elders and sharing any pertinent information relative to the emergency.



2. Invoicing and Payment: Ensuring payments to vendors so that they may continue their essential functions.
3. Payroll: Ensure continuance of payroll to EOEA employees.
4. Information and Technology: Ensure Senior Information Management System (SIMS) remains functional on a statewide basis.

In the event of an emergency, EOEA's primary goal is to communicate directly with all essential service providers within the elder care system, most importantly, those community-based, direct care service providers who care for frail homebound elder citizens. Essential services include select home care services, ombudsmen services, nutrition services, information and referral, and protective services provided by 28 regional nutrition programs and 27 regional ASAPs, 23 AAAs and ADRCs.

The exchange of communications during an emergency is crucial to providing accurate and beneficial information to elders, vendors and caregivers. EOEA program directors have been trained to have all essential contact information (phone, email, address) for service providers, stakeholders, other state agency staff, Massachusetts Emergency Management Agency (MEMA) staff, press contacts, legislative leaders, and the Governor's office. A Public Information Officer (PIO) is delegated responsibility for maintaining up-to-date contact with all local media outlets and how to contact that outlet/person in an emergency. The PIO is responsible for receiving and acquiring briefings from emergency response staff as the situation unfolds and throughout the recovery period.

Based on the severity of the situation and the projected duration of the crisis, EOEA's Plan ensures that ASAP/AAAs and Nutrition programs are notified in a timely manner to activate their own COOPs to continue essential nutrition and home care services for frail and homebound elders and share any pertinent information relative to the emergency.

During emergencies where telecommunications and information technology systems and applications are breached, essential and preferred services protocols (Notification of Providers, Administration & Finance Operations and Human Resource Functions) will be expected to be in place immediately following restoration. While essential and preferred functions are still deemed necessary to complete, some forms of notification, and/or communication of planned emergency protocols during a prolonged black/brown out or catastrophic event may not be accessible. Upon the restoration of connectivity, developed protocols, communication plans and notification protocols with Providers and AAA/ASAPs will be reestablished immediately following the occurrence and all functions will be retroactive (billing, payments, payroll, consumer intakes etc.) to the first day of the occurrence.

The value of designing and disseminating emergency preparation instructions for individual elder preparation is fundamental to State Unit management. Preparing strategies and offering recommendations to individual elders and caregivers across



the Commonwealth, a person-centered approach is an essential tool of medical emergency preparation. The following list is available on the EOEA website and is adapted from the Mayo Clinic Senior Health strategy:

1. **Names of the consumer's doctors.** If you don't know anything else, this is probably the most important piece of information. Why? Chances are good that the consumer's doctors can provide much of the rest of the information needed as well as more details about specific health histories.
2. **Birth dates.** Often medical records and insurance information are cataloged according to birth date. This can improve communication in an emergency or crisis.
3. **List of allergies.** Especially important if the consumer is allergic to medication — penicillin, for example.
4. **Major medical problems.** Includes such diseases as diabetes or heart disease.
5. **List of medications.** Particularly important that a doctor know if the consumer uses blood thinners, for example.
6. **Cultural concerns / Religious beliefs.** Important if beliefs might impact care.
7. **Insurance information.** Includes Medicare, MassHealth (Medicaid) and third party coverage. Know the name of the coverage and policy number.
8. **Prior surgery.** List past medical procedures, such as cardiac bypass surgery.
9. **Lifestyle information.** Does the consumer drink alcohol or use tobacco?
10. **Assistive equipment.** Does the consumer use a cane, wheelchair, hearing aid, false teeth, or other durable equipment?
11. **Health care proxy.** Designating another person to act as the consumer's health care agent with the authority to make all health care decisions (unless specifically limited) for the grantor should he/she become unable to make or communicate those decisions.

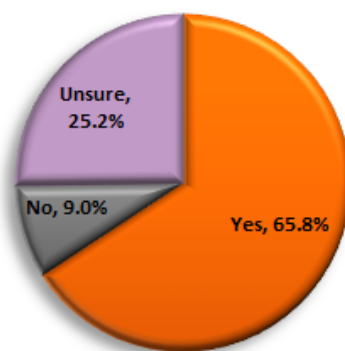
EOEA's focus on person-centered planning communicates the value of developing emergency preparation procedures across the Massachusetts aging network. Throughout the network plans are developed to assess and provide referrals for consumers who are experiencing a crisis due to a disaster of natural or human origin. Providers are required (in the case of contracts with EOEA) or encouraged to maintain written procedures addressing specific types of emergencies affecting the organization's operations and consumers including power outages, fires, medical emergencies, bomb threats, radiological threats, workplace violence and



other incidents that may require different forms of responses. Written procedures are maintained for emergency evacuation of the facility following a disaster that impacts the immediate area surrounding the facility and potentially threatens staff safety. The evacuation procedure designates exits, specifies an assembly area, and includes provisions for ensuring that everyone has left the building. Special arrangements for helping staff or visitors with a disability exit the building must also be addressed;

A measure of person-centered planning can be appreciated in how the network addresses the needs of consumers needing special assistance during an emergency. Among 222 COAs that responded to the Massachusetts Needs Assessment Survey – Municipal Questionnaire (Attachment J), the following figure shows that nearly two of every three COAs reported that their communities maintained a registry or record of people who require additional assistance during an emergency.

COAS THAT MAINTAIN A REGISTRY OF PEOPLE WHO REQUIRE ADDITIONAL ASSISTANCE



### Section 307(a)(30)

*The plan shall include information describing the involvement of the head of the State agency in the development, revision, and implementation of emergency preparedness plans, including the State Public Health Emergency Preparedness and Response Plan.*

The Massachusetts Emergency Management Agency (MEMA) is the state agency with primary responsibility for ensuring the state's response to disasters. Over the past several years, in coordination with various state offices, including EOE, MEMA directed a team of officials charged with supporting and coordinating state responses to emergencies at the State Emergency Operations Center (SEOC). In an effort to refocus emergency response planning, strengthen the program and leverage resources, MEMA is currently evaluating the scope of state-level response and coordination.

As currently conceived, the Massachusetts Statewide Mass Care and Shelter Planning Project is a statewide shelter strategy to establish a coordinated approach to the provision of mass care and shelter services. The statewide shelter strategy is intended to help increase overall mass care and shelter capabilities, identify a





process to help communities when they are overwhelmed, and better allocate mass care and shelter resources throughout the Commonwealth. While the Project is still under development, the SUA continues to be represented as a partner in presenting the unique needs of elders during emergencies. The plan is that EOEa and the elder network will maintain the present focus of offering strategies and solutions related to sheltering and feeding disaster victims.

On a more provincial level, EOEa has joined with the Massachusetts DPH and the American Red Cross of Massachusetts Bay in forming a partnership that provides emergency preparedness outreach to elders. The partnership seeks to provide a series of informational tools and resources to help ensure that elders in the community - and the caregivers who support them - are better prepared for emergencies and disasters of all kinds. The link to the webpage is, [www.mass.gov/eohhs/gov/departments/dph/programs/emergency-prep/elder-emergency-preparedness.html](http://www.mass.gov/eohhs/gov/departments/dph/programs/emergency-prep/elder-emergency-preparedness.html), and includes the following resources:

- Disaster Preparedness for Seniors by Seniors (preparation guide)
- Elder Preparedness Resource Sheet (Attachment G)
- Memorandum to Local Public Health
- Memorandum to Local Councils on Aging
- Personal Preparedness Video

The Personal Preparedness Video discusses the important issues of flu prevention and personal emergency preparedness, as well as fire prevention and telecommunications tools. A production of *Senior Scene*, a cable program produced by the Executive Office of Elder Affairs and taped at the Belmont Media cable station, the video explores the spectrum of services and volunteer opportunities for Massachusetts' seniors and persons with disabilities.

## **Section 705(a)(7)**

In order to be eligible to receive an allotment under this subtitle, a State shall *include in the State plan submitted under section 307:*

*(7) a description of the manner in which the State agency will carry out this title in accordance with the assurances described in paragraphs (1) through (6).*

*(Note: Paragraphs (1) through (6) of this section are listed below)*

*In order to be eligible to receive an allotment under this subtitle, a State shall include in the State plan submitted under section 307:*

*(1) an assurance that the State, in carrying out any chapter of this subtitle for which the State receives funding under this subtitle, will establish programs in accordance with the requirements of the chapter and this chapter;*

*(2) an assurance that the State will hold public hearings, and use other means, to obtain the views of older individuals, area agencies on aging, recipients of grants under title VI, and other interested persons and entities regarding programs carried out under this subtitle;*





*(3) an assurance that the State, in consultation with area agencies on aging, will identify and prioritize statewide activities aimed at ensuring that older individuals have access to, and assistance in securing and maintaining, benefits and rights;*

*(4) an assurance that the State will use funds made available under this subtitle for a chapter in addition to, and will not supplant, any funds that are expended under any Federal or State law in existence on the day before the date of the enactment of this subtitle, to carry out each of the vulnerable elder rights protection activities described in the chapter;*

*(5) an assurance that the State will place no restrictions, other than the requirements referred to in clauses (i) through (iv) of section 712(a)(5)(C), on the eligibility of entities for designation as local Ombudsman entities under section 712(a)(5);*

*(6) an assurance that, with respect to programs for the prevention of elder abuse, neglect, and exploitation under chapter 3—*

*(A) in carrying out such programs the State agency will conduct a program of services consistent with relevant State law and coordinated with existing State adult protective service activities for:*

- (i) public education to identify and prevent elder abuse;*
- (ii) receipt of reports of elder abuse;*
- (iii) active participation of older individuals participating in programs under this Act through outreach, conferences, and referral of such individuals to other social service agencies or sources of assistance if appropriate and if the individuals to be referred consent; and*
- (iv) referral of complaints to law enforcement or public protective service agencies if appropriate;*

*(B) the State will not permit involuntary or coerced participation in the program of services described in subparagraph (A) by alleged victims, abusers, or their households; and*

*(C) all information gathered in the course of receiving reports and making referrals shall remain confidential except—*

- (i) if all parties to such complaint consent in writing to the release of such information;*
- (ii) if the release of such information is to a law enforcement agency, public protective service agency, licensing or certification agency, ombudsman program, or protection or advocacy system; or*
- (iii) upon court order.*

In addressing Section 705 (a)(7), EOEA makes assurances that the SUA and AAAs are joining resources, strategies and efforts to focus on elder neglect and abuse prevention, elder and public input regarding protective service needs, advocating for elders' rights within long-term care facilities, and continuing support of legal services for elders. Title III-B and VII Federal funding links with approximately \$16.2M of State Protective Service funding, creating increased opportunities to develop new choices and strengthen the elder rights protection activities in Massachusetts. In addressing the declared assurances, the aging network exercises a myriad of activities that protect the most vulnerable elders, those who experience abuse, neglect and financial exploitation.

EOEA is required by law to administer a statewide system for receiving and investigating reports of elder abuse, and for providing needed protective services to abused elders when warranted. To fulfill this responsibility, EOEA's has established 21 designated Protective Services (PS) agencies throughout the



Commonwealth to respond to reports of elder abuse. Elder abuse includes physical, emotional and sexual abuse, neglect by a caregiver, self-neglect and financial exploitation. The goal of protective services is to remedy or alleviate the abusive situation and to prevent the reoccurrence of abuse.

Elder abuse reports may be made to the appropriate designated PS agency or the statewide Elder Abuse Hotline (1-800-922-2275), which operates on a seven days a week, 24 hours a day basis. Typically, elder abuse reports are made to PS agencies during normal business hours and to the Hotline during after-hours periods, on weekends and holidays.

Anyone can make an elder abuse report. However, the law requires certain professionals to report suspected incidents of abuse. Mandated reporters who fail to make elder abuse reports when appropriate are subject to a fine up to \$1,000. In addition, the law provides mandated reporters with immunity from any civil or criminal liability that otherwise could result from making a report, provided the reporter did not commit the abuse. Persons who are not mandated reporters have the same immunity, as long as they make a report in good faith.

Once an elder abuse report is received, a trained PS caseworker is assigned to investigate the allegations. If the investigation results in the confirmation of one or more types of abuse, the elder is offered an array of services to address the situation. In cases of criminal abuse, the PS agency must make a report to the District Attorney for possible prosecution. An elder who has the capacity to make informed decisions has the right to refuse services. However, court ordered services must be sought on behalf of abused elders who are unable to make informed decisions, and are at risk of serious harm. In addition, protective services must be provided in the least restrictive and appropriate manner possible; in-home and community based services are given preference over institutional placement.

Developed as a short term crisis intervention program, PS caseworkers work with the elder, family and community agencies offering services that may include: counseling; safety planning; substance abuse treatment; mental health services; family intervention; homemaker/health aide services; emergency food or fuel; transportation; housing; legal assistance; financial assistance; medical services and therapies; and, advocacy. Casework is provided without regard to income. Additional services are provided at no charge to elders who are unable to pay, although elders who can afford services may be charged all or part of the cost.

All elders (persons 60 and older), regardless of income, living in a community setting are eligible to receive PS if they are abused, neglected or exploited. PS are designed to help elders who have an on-going personal relationship with the abuser. This is significant as elders are most at risk from people that are known to them, such as spouses, adult children, grandchildren, other family members, friends and caregivers. Elders who are victims of random street crime or scams by unscrupulous entrepreneurs are referred to the police and other law enforcement agencies for assistance, but may also be referred to PS for self-neglect if the actions are impacting their ability to meet basic daily needs.



Throughout a case, the rights of competent elders to accept or decline a particular course of action are protected. Consistent with this right to self-determination, an elder who is able to make informed decisions about his/her situation has a right to refuse an investigation, contact with certain individuals, particular services or all intervention. Caseworkers make reasonable attempts to build rapport with elders and break through any existing resistance. However, competent elders have the final say regarding the progress of their cases, no matter how poor the choices may be. The only exceptions to the elder's right to refuse are:

1. When the elder is refusing because of duress or intimidation (for investigation only); or
2. When the elder lacks the ability to make informed decisions or capacity to consent is questionable.

In the selection of service options, priority is given to those services that are least restrictive to the elder's autonomy and freedom. The complexity of elder abuse and the differing needs of each situation require diverse interventions. In-home services are preferred over institutionalization as they are less restrictive. However, guardianship and/or placement, although extremely restrictive, may be the most appropriate intervention for a significantly demented, wandering elder. In addition, PS, based on regulatory authority, may need to seek court intervention in certain high risk cases, whether to gain access, gather information, assess capacity or provide services.

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Ann L. Hartstein, Secretary

July 1, 2013

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Date

Executive Office of Elder Affairs  
Commonwealth of Massachusetts



## **Attachment C – Intrastate Funding Formula and 2014 Allocation Plan**

The Massachusetts Intrastate Funding Formula (IFF) targets older individuals with greatest economic need and older individuals with greatest social need, with particular attention to low-income individuals and those living in rural areas. The purpose of the Massachusetts IFF is to allocate funds in accord with the proportion of potential consumers in each Planning and Service Area (PSA). Special emphasis is given to individuals 60+ with the greatest economic or social needs that are identified by the best demographic data available derived from EOEA's research and Needs Assessment efforts.

### **Formula Explanation and Methodology**

Historically, EOEA's distributed Title III funding using the following formula calculations when funds available were in excess of each AAAs Federal Fiscal Year (FFY) 1984 allocation. A "hold harmless" principle was applied in the application of the formula such that no AAA would receive an allocation less than its FFY 1984 allocation; funding available over and above the 1984 base allocation was distributed using current Census data. Given modifications to elder demographics, through analysis of Census figures, and in a desire to distribute funding based on current information, EOEA has worked with the AAA network to more equitably allocate Title III funding.

In adopting 2010 Census data in navigating a more current funding distribution, (except as detailed below), EOEA considers the Intrastate Funding Formula to represent a methodology that is fair to all AAAs and better exemplifies the elder demographics of the Commonwealth. EOEA considers the Massachusetts IFF to be a sound illustration of the OAA mandate to target funding and services to persons sixty (60) years of age or older with preference in service delivery to older persons in greatest social or economic need, with particular attention to low-income older individuals, including low-income minority older individuals, older individuals with limited English proficiency, and elders living in rural areas.

EOEA distributes Title III funding using the formula as detailed below. The formula is comprised of six basic components that are weighed as to the relative significance of each component within the total formula. The total of the numerical weights for the weighted components of the formula is ten (10).

Each PSA's formula funding factor is the sum of its individual percent of state totals of the identified population factor times each factor's weight divided by ten. It is applied to available funding to determine AAA allocations.

Specific components of the formula, together with the numerical weight assigned to each:

<u>Formula Component</u>	<u>Assigned Weight</u>
1. Proportion of persons aged 75 and over in PSA	1.00
2. Proportion of persons living alone aged 60 and over in PSA	1.50



3. Proportion of low income persons aged 60 and over in PSA	4.75
4. Proportion of minority persons aged 65 and over in PSA	2.00
5. Proportion of persons living in rural towns aged 65 and over in PSA	.50
6. Proportion of persons aged 60 and over in PSA	.25

#### Methodology for using the formula:

- Step One                      For each Area Agency on Aging:
- Calculate the 75+ population as a percent of the State's total 75+ population, multiply the results by 1.00.
  - Calculate the 60+ living alone population as a percent of the State total 60+ living alone population, multiply the result times 1.50.
  - Calculate the 60+ low-income population as a percent of the State's 60+ low-income population, multiply the result times 4.75.
  - Calculate the 65+ minority population as a percent of the State's total 65+ minority population, multiply the result times 2.00.
  - Calculate the 65+ rural towns population as percent of the State's rural town population, multiply the results times 0.50.
  - Calculate the 60+ population as a percent of the State's total 60+ population, multiply the results times 0.25.
  - Add the results of Step One (a) through (f) and divide by 10. This is the formula funding ratio.
- Step Two                      For each Area Agency on Aging, multiply the funds available for distribution times each AAA's formula funding ratio. This figure, then, is the Area Agency's current year Title III allocation.

It should be noted that the above formula methodology does not apply to program funding under the LTC Ombudsman Program. LTC Ombudsman services in Massachusetts are funded from two sources of Older Americans Act funding; Title III-B Supportive Service funding and Title VII Ombudsman funding are combined to form the total available funding under the LTC Ombudsman Program. Additionally, the funding distribution of LTC Ombudsman Program funding to the AAAs in Massachusetts is rooted in a historical base, with any additional funding that may be available, being awarded to the AAA's based on the number of facility beds located in the PSA.

The following table, "FFY2014 Estimated Title III Resource Allocation Plan", lists the Area Agencies on Aging and their projected FFY 2014 allocations for services provided under Title III



and VII of the Older Americans Act. The table represents the distribution of funding based on estimated ACL funding for FFY2014 and the preceding Intrastate Funding Formula methodology submitted for approval to the Administration for Community Living.



## FFY2014 ESTIMATED TITLE III RESOURCE ALLOCATION PLAN

AREA PLAN ADMINISTRATION, SUPPORTIVE SERVICES, CONGREGATE MEAL NUTRITION SERVICES, HOME DELIVERED MEAL NUTRITION SERVICES,  
PREVENTIVE HEALTH SERVICES, FAMILY CAREGIVER SERVICES AND LONG TERM CARE OMBUDSMAN SERVICES

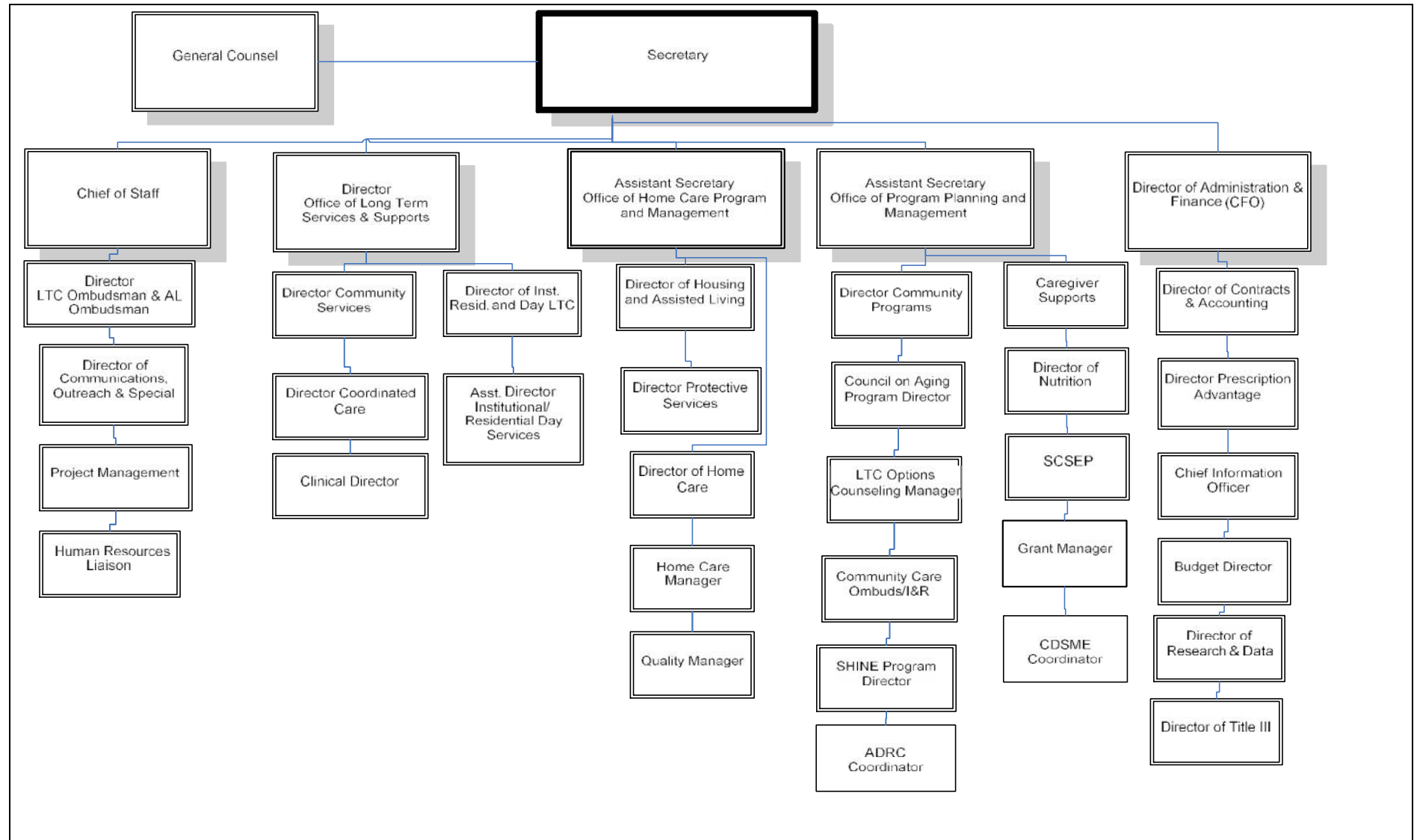
AREA AGENCY ON AGING	AREA PLAN ADMIN	TITLE III - B SUPPORTIVE SERVICES	TITLE III-C CONGREGATE MEAL SERVICES	TITLE III-C HOME DELIV. MEAL SERVICES	TITLE III - D PREVENTIVE HEALTH EV-B SVS	TITLE III - E FAMILY CAREGIVER SERVICES	LONG TERM CARE OMBUDSMAN SERVICES	TOTAL TITLE III FUNDING
BAYPATH	110,205	143,319	179,615	79,141	9,963	68,799	63,821	654,863
BERKSHIRE COUNTY	78,773	205,221	251,724	110,913	13,377	94,889	66,376	821,273
BOSTON COMMISSION	296,346	1,079,729	1,309,766	577,099	74,597	438,348	171,005	3,946,890
BRISTOL COUNTY	115,270	291,717	356,774	157,198	23,846	135,722	71,967	1,152,494
CAPE COD & ISLANDS	62,392	281,020	338,551	149,170	26,120	117,316	85,830	1,060,399
CENTRAL MASS	312,615	603,546	744,906	328,216	41,621	272,873	268,585	2,572,362
CHELSEA/REVERE/WINTHROP	56,883	122,409	152,111	67,021	9,950	55,218	40,415	504,007
COASTLINE	90,459	218,421	266,874	117,587	16,057	92,744	44,809	846,951
FRANKLIN COUNTY	46,077	168,723	204,127	89,942	10,311	71,390	45,802	636,372
GREATER LYNN	69,974	152,918	189,541	83,514	11,150	72,641	41,293	621,031
GREATER SPRINGFIELD	82,515	347,986	420,865	185,437	24,129	147,784	71,794	1,280,510
HESSCO	44,214	120,319	146,534	64,565	7,088	47,266	47,151	477,137
HIGHLAND VALLEY	42,580	165,340	201,831	88,928	10,970	70,854	44,062	624,565
MERRIMACK VALLEY	152,269	459,354	558,957	246,282	33,115	196,390	126,205	1,772,572
MINUTEMAN	154,242	151,526	193,530	85,272	10,976	73,445	52,373	721,364
MYSTIC VALLEY	110,074	247,950	303,507	133,730	17,789	107,934	-	920,984
NORTH SHORE	41,750	140,278	170,646	75,189	7,560	52,538	121,556	609,517
OLD COLONY P C	171,713	294,526	364,908	160,783	21,616	139,207	113,706	1,266,459
SENIORCARE	25,717	128,816	155,551	68,537	5,881	39,135	44,948	468,585
SOMERVILLE/CAMBRIDGE	95,099	186,917	231,434	101,972	12,210	80,147	39,351	747,130
SOUTH SHORE	119,268	253,150	311,685	137,332	16,942	120,175	65,771	1,024,323
SPRINGWELL	81,087	287,595	348,522	153,562	17,078	116,065	97,907	1,101,816
WESTMASS ELDERCARE	86,818	176,030	216,413	95,354	12,666	69,601	41,101	697,983
<b>TOTALS</b>	<b>\$ 2,446,340</b>	<b>\$ 6,226,810</b>	<b>\$ 7,618,372</b>	<b>\$ 3,356,744</b>	<b>\$ 435,012</b>	<b>\$ 2,680,481</b>	<b>\$ 1,765,828</b>	<b>\$ 24,529,587</b>





## Attachment D: Executive Office of Elder Affairs Organizational Chart

### **Commonwealth of Massachusetts – Executive Office of Elder Affairs - 2013**





## **Attachment E: Massachusetts Aging Agenda**

Society cannot thrive or even survive without the continuous active participation of all people as they age. Each of us, both individually and collectively, has a stake in building an environment in which every person has an equal opportunity to participate in all aspects of civic life. We believe all adults, during each stage of the lifespan, should have the full and free enjoyment of these fundamental principles for aging well.

- To live in a society that understands the positive aspects of aging, recognizes the interdependence we rely upon to meet life's challenges, and values the intergenerational sharing of life, wealth, wisdom, caring and caregiving.
- To attain economic security through a combination of earning an adequate income, saving money over one's lifetime, and learning basic financial skills to avoid financial hazards and financial exploitation.
- To attain and sustain the best possible physical, cognitive, and mental health and have the opportunity to benefit from proven methods for maximizing and improving one's abilities, health and happiness.
- To reside in affordable housing suitably designed to accommodate the predictable changes in functional abilities we'll likely experience as we age.
- To exercise control over managing one's own life and participate in a wide range of civic, cultural, learning, spiritual and recreational opportunities for as long as possible.
- To have access to social assistance services, including protection against abuse and neglect, that can be readily provided in an efficient and appropriate manner for diverse populations.
- To have an adequate array of flexible, reliable transportation options.
- To have access to affordable long-term services and supports that can sustain individuals in the setting of their choice, including a consumer's full participation in managing services.
- To lend meaningful support to caregivers to preserve the beneficial impact caregiving has upon the caregiver, the person depending upon them and society at large.

An illustration of the fundamental principles for aging well follows:



## Attachment E: Aging Agenda – Nine Principles of Aging Well





## **Attachment F: Executive Office of Elder Affairs - Program and Service Descriptions**

Through a statewide elder network, the Executive Office of Elder Affairs provides services locally via Area Agencies on Aging (AAA), Aging Services Access Points (ASAP), Aging and Disability Resource Consortia (ADRC), Councils on Aging (COA) and senior centers in communities across the Commonwealth. The following identifies programs and services offered by a network dedicated to promoting the integrity, rights and independence of all elders and their caregivers.

<b>Program/Service Category</b>	<b>Program Description</b>
Adult Day Health (ADH)	A community based day program providing nursing and therapeutic services and oversight for members in an effort to postpone nursing facility placement. MassHealth pays for Adult Day Health services for members who need assistance with one (1) activity of daily living or one skilled service. Services provided include nursing, therapy, nutrition, dietary counseling, case management, activities, and assistance with activities of daily living.
Adult Foster Care (AFC)	A MassHealth program that provides personal care services in a family-like setting to elderly or disabled individuals. AFC provides assistance with Activities of Daily Living (ADLs), nursing oversight and care management in a setting that provides 24 hour supervision.
Assisted Living	Assisted Living usually refers to a combination of housing and supportive services including personal care (such as bathing and dressing assistance) and household management (such as meals and housekeeping aid). Assisted Living is a residential option which stresses privacy, dignity, autonomy, and individuality. It is a housing option for seniors and adults with disabilities who need daily help with one or more personal care activities but do not need full-time nursing care. Elder Affairs certifies Assisted Living Residences in Massachusetts.
Assisted Living Ombudsman Program	Improves the quality of life for assisted living residents in the areas of health, safety, welfare or resident rights. The Assisted Living Ombudsman acts as a mediator and resolves problems or conflicts between the assisted living facility and its residents. The Ombudsman serves as an advocate for resident rights, promoting dignity, autonomy and respect for residents.
Chronic Disease Self-Management Education (CDSME)	A program based on evidence-based, self-management programs that provide older adults and adults with disabilities with education and tools to help them better manage chronic conditions such as diabetes, heart disease, arthritis, HIV/AIDS and depression. The purpose of these programs is to maintain or improve participant health status, and strengthen and expand sustainable long term services and supports systems.



Program/Service Category	Program Description
Community Care Ombudsman Program (CCO)	Assists people age 60 and over who receive home care, day care services and other community services. The CCO responds to inquiries from elders and their families; educates consumers about their rights and responsibilities; counsels consumers about concerns with their services; refers consumers to appropriate resources for help and investigates and resolves complaints through mediation.
Community Choices Program	Provides intensive services to frail elders at imminent risk of nursing home placement. Choices' consumers must be receiving services through the Medicaid Home and Community-Based Services Waiver. They have access to a rich menu of home care services as well as Title XIX state plan services (such as adult day health and home health services) available to MassHealth members. The ability to provide Choices consumers with extensive home care services and supports allows them to remain in the community, avoiding admission to a nursing facility.
Congregate Housing	Congregate Housing for people 60+ or people with disabilities, who meet financial guidelines, offers private bedrooms but shares one or more of the following: kitchens, dining rooms, bathrooms. Services are made available to aid residents in managing Activities of Daily Living in a supportive, but custodial living environment designed to integrate the housing and services needs of elders and disabled individuals. The goal of Congregate Housing is to increase self-sufficiency through the provision of supportive services in a residential setting. Congregate Housing is neither a nursing home nor a medical care facility.
Continuing Care Retirement Communities (CCRC)	CCRCs offer an environment and the services necessary for residents to "age in place." As a person's personal and health care needs change, they are able to remain at the retirement community. CCRCs often have a variety of housing on one campus, from townhouses or "cottages" for independent living to studio apartments for people in supportive living programs. In addition to providing health services, CCRCs offer, usually for a set monthly fee, a package of services, activities, and amenities that are designed to maximize the resident's independence. The composition of service packages varies greatly by CCRC.
Coordination of Care Program (COC)	Screens MassHealth members and applicants for clinical eligibility for MassHealth services including nursing facilities, adult day health (ADH), adult foster care (AFC), Group Adult Foster Care (GAFC), Program of All-Inclusive Care of the Elderly (PACE), Enhanced Community Options Program (ECOP), the Community Choices, Home and Community-Based Waiver Services (HCBW) and other community based MassHealth services.



Program/Service Category	Program Description
Council on Aging (COA)	A municipally appointed agency that provides services to elders, families and caregivers by providing social and health services, advocacy, and information and referral services for elders at the local level. While each COA is unique to its community, most councils offer information and referral, transportation, outreach, meals (congregate and home delivered), health screening, fitness and recreation programs and volunteer services. Councils on Aging are municipal agencies that receive funding under formula and service incentive grants, as well as technical assistance from the Elder Affairs.
Day Habilitation Services	A community based day program providing services that focus on skill development. This program is available to MassHealth members who have a diagnosis of mental retardation or a developmental disability and are able to benefit from skill development. The skill development is based on a service plan that is designed to help the member become more independent in his or her environment.
Durable Medical Equipment (DME)	Medical equipment provided to MassHealth members that is ordered by a doctor for use in the home. These items, such as walkers, wheelchairs, and hospital beds, must be reusable. Durable medical equipment is paid for under Medicare, subject to a 20% coinsurance of the Medicare-approved amount.
Enhanced Community Options Program (ECOP)	Provides home care services to frail elders who meet current clinical criteria for nursing facility placement and therefore require higher levels of service. ECOP provides a greater amount of services for these elders with the goal of allowing them to remain in the community and avoid institutional care.
Family Caregiver Support Services (Title III-E)	A program offered by the Executive Office of Elder Affairs in partnership the Aging Service Access Points (ASAP) and Area Agencies on Aging (AAA). The program provides information and referrals, training, counseling, support groups, respite care options, and other services to family caregivers.
Group Adult Foster Care (GAFC)	A MassHealth program that pays for personal care services for eligible seniors and adults with disabilities who live in GAFC –approved housing. Housing may be an assisted living residence or specially designated public or subsidized housing.
Guardianship Program	In situations where more restrictive actions are necessary to ensure an elder’s safety, Elder Affairs contracts with five not-for-profit agencies across the state to provide conservator and guardianship services to PS consumers who are unable to make informed decisions and are at risk of serious harm. A conservator is appointed by the court to manage the finances of another person, while a guardian is responsible for managing both the financial and personal care needs of his/her ward.



Program/Service Category	Program Description
Home Care Program (HC)	<p>The Massachusetts Home Care Program provides support services to elders with daily living needs to help maintain independent community living. Services are designed to encourage independence and ensure dignity. The program also supports families caring for elders in order to encourage and relieve ongoing care giving responsibilities.</p> <p>The Home Care Program is administered in coordination with Aging Services Access Points (ASAPs), located in communities throughout the Commonwealth of Massachusetts. The program provides homemaker, personal care, day care, home delivered meals, transportation, and an array of other community support services to help elders remain in their homes.</p>
Home Health Services	<p>Services provided to MassHealth members who may be homebound and require a skilled nursing or skilled therapy service. Covered services include nursing, home health aide, physical therapy, occupational therapy, and speech language therapy. All home health services must be furnished under a plan of care established individually for the member by the member's physician.</p>
Hospice Services	<p>MassHealth covered services for all MassHealth members who are either living in the community or in a nursing facility. For those who elect to receive Hospice Services, the service is provided as an all-inclusive medical benefit (that is, nursing, physician, counseling, homemaker, home health aide, therapies, drugs, and durable medical equipment and medical supplies are no longer separately covered).</p>
Information and Resources (I&R)	<p>Resources include Elder Affairs' family-friendly 1-800-AGE-INFO (1-800-243-4636) telephone line and companion website <a href="http://www.800ageinfo.com">www.800ageinfo.com</a> for providing Massachusetts elders and their families with a one-stop connection to state and local programs and services, even on nights and weekends.</p>
Long Term Care Ombudsman Program	<p>The purpose of the Long Term Care Ombudsman Program is to investigate and resolve complaints made by, or on behalf of, older persons who are residents of long-term care facilities. The funding resources for the LTC Ombudsman program include both Title III-B and Title VII resources.</p>
MassMedLine (Pharmacy Outreach Program)	<p>Operated by the Massachusetts College of Pharmacy and Health Sciences, under contract with the Massachusetts Executive Office of Elder Affairs, as a public service to the people of the Commonwealth. Any Massachusetts resident may utilize the MassMedLine toll-free telephone number, 1-866-633-1617, and website, <a href="http://www.massmedline.com">www.massmedline.com</a> to inquire about prescription drug medication support programs that are available at low cost or free of charge. Consumers are welcome to ask any questions regarding their medications and general health.</p>





Program/Service Category	Program Description
Money Management Program	The Massachusetts Money Management Program is a free service that assists low-income elders who might be at risk of losing their independence due to their inability to pay basic rent, food and utility bills on time. Oftentimes, these elders are homebound, disabled, visually impaired, or confused, and without family nearby to help them. Trained, insured, supervised volunteers assist their consumers by writing checks, balancing their checkbooks and ensuring that bills are paid on time. Money management is a primary prevention program which helps prevent financial exploitation and enables elders to remain safe and secure in their homes.
Nursing Services	Provides continuous nursing services to MassHealth members living in the community who require more than a two-hour visit. The service is provided by both home health agencies and independent nurses and requires prior authorization from MassHealth.
Nutrition Program: Congregate and Home Delivered Meals (Title III-C1 and C2)	The Nutrition Program is a federal (Title III-C1 and C2) and state funded program, and the second largest program operated by the Executive Office of Elder Affairs. Twenty-seven nutrition programs located throughout the state serve over eight and a half million meals to seniors each year. Meals are provided at more than 400 congregate meal sites and are delivered to frail elders in their homes. Nutrition Services help to address a number of problems faced by many elders, including poor diets, health problems, food insecurity, and loneliness. Key nutrition services include nourishing meals, as well as nutrition screening, assessment, education, and counseling, to ensure that older people achieve and maintain optimal nutritional status.
Options Counseling Program	Counseling provided to an older person, or an adult of any age with a disability, needing supportive services to help with basic activities such as personal care, transportation, nutrition or medication management. The counselor assists with locating and evaluating options for care with the individual or their family member or caretaker. The support of a knowledgeable, caring counselor provides unbiased information about the range of community and institutional services and how to access them, and supports the individual during the decision-making process by helping to determine a plan and the steps to achieve it. This may be accomplished in a single session or over several sessions.
Personal Care Attendant Program (PCA)	A MassHealth program under which personal care management services, fiscal intermediary services, and PCA services are available to MassHealth members. PCA services are defined as physical assistance with Activities of Daily Living (ADLs, such as transfers, taking medications, bathing/grooming, and engaging in passive range of motion exercises) and Instrumental Activities of Daily Living (IADLs, such as meal preparation and clean-up, housekeeping, shopping, and transportation to medical providers) provided to a member by a PCA in accordance



Program/Service Category	Program Description
	with the member's authorized evaluation or reevaluation, service agreement and germane program regulations.
Prescription Advantage (PA)	Prescription Advantage is the state prescription drug assistance program for seniors and people with disabilities in Massachusetts. Prescription Advantage is available to residents of Massachusetts who are not MassHealth or CommonHealth members. For members enrolled in Medicare, Prescription Advantage supplements the Medicare prescription drug benefit by helping to pay for medications covered by their Part D plan.
Program of All-inclusive Care for the Elderly (PACE)	A full-service Medicare and Medicaid managed care program that serves frail individuals 55 and older who meet the clinical criteria for admission to a nursing facility, and who, at the time of enrollment in PACE, are able to remain in the community with supports. PACE sites use an interdisciplinary team of clinicians in an expanded adult day health model to provide and manage all health, medical and social service needs.
Protective Services (PS)	A statewide system for receiving and investigating reports of elder abuse, and for providing needed protective services to abused elders when warranted. Elder abuse includes physical, emotional and sexual abuse, neglect by a caregiver, self -neglect and financial exploitation. The goal of protective services is to remedy or alleviate the abusive situation and to prevent the reoccurrence of abuse.
Senior Care Options (SCO)	An innovative full-service Medicare and Medicaid managed care program that is being offered to eligible Mass Health members age 65 and over, at all levels of need, in both the community and institutional settings. Qualified senior care organizations have been selected to contract with MassHealth and the Centers for Medicare and Medicaid Services (CMS), and have established large provider networks that are coordinating and delivering all acute, long-term care, and mental health and substance abuse services. Senior Care Options is based on a geriatric model of care, and is available nearly statewide.
Senior Community Service Employment Program (SCSEP)	Places eligible applicants in nonprofit or public/community service agencies where they receive on-the-job training for at least 20 hours per week. Participants are paid at least the current minimum wage during their temporary assignments and work with SCSEP to locate permanent part-time or full-time employment. Participants benefit by receiving assistance in developing job search skills and in locating a permanent job; obtaining paid work experience to improve job skills; and developing new skill capacity. The ultimate goal of the program is to provide the participant with the tools necessary to obtain unsubsidized employment.



Program/Service Category	Program Description
SHINE Program	The SHINE Program (Serving Health Information Needs of Elders) is a state health insurance assistance program that provides free health insurance information, counseling and assistance to Massachusetts residents with Medicare and their caregivers. The SHINE Program is administered by the Executive Office of Elder Affairs in partnership with elder service agencies, social service and community based agencies and Councils on Aging.
Title III-B Supportive Services	Provides for home and community-based services that fund a broad array of services enabling elders to remain in their homes for as long as possible.
Title III-D Preventive Health Services	Title III-D seeks to initiate programs designed to help older adults prevent/manage chronic disease and increase healthier lifestyles. Through the dissemination of Evidence-Based (EB) Program initiatives that drive the healthy aging effort, AAAs in collaboration with community partners, use funding to address disease prevention and health promotion services and information for consumers at senior centers, meal sites, and other appropriate locations.
Title VII Vulnerable Elder Rights Protection Services	Title VII under the Older Americans Act provides funding to provide elder right services to vulnerable elders. The two programs funded are Elder Abuse Prevention and Long Term Care Ombudsman services. Elder Abuse Prevention funding is used to enhance the State Protective Services program with centralized management and network training resources. The Long Term Care Ombudsman program assists residents of nursing, and board and care facilities (known in Massachusetts as “rest homes”) with complaint investigation and resolution, providing information and referral, and advocating for change in the long term care system.



## **Attachment G: Embrace Your Future**



Massachusetts is involved in the national initiative to encourage adults of all ages to plan for their future long-term care needs. The Embrace Your Future resource guide offers practical advice, steps and a range of strategies for planning for long-term care.

In Massachusetts, and throughout the United States and abroad, people are living longer and staying healthier longer than ever before. As we enjoy extended lives, the likelihood that at some point we will need long-term supports also increases. Chronic disease and disabilities are more prevalent in our later years. Because we are living longer, we need to be thinking about and planning for the futures that we want for ourselves and our loved ones. The Embrace Your Future guide presents some helpful resources and ways to think about the future for yourself and your loved ones. The guide is designed to help consumers learn how to plan for their future long-term support needs; some of the areas for consideration, include:

- Where to Start
- Lifestyle Planning
- Planning for Your Care
- Decide Who You Can Count On for Help
- Learn What Your Community Has to Offer
- Getting Legal Matters in Order
- Staying at Home
- Financial Planning for Long-Term Supports
- Long-Term Care Insurance
- Concerns about Care
- Principles for Attaining the Best Quality of Life as We Age
- To Do Checklist

The complete Embrace Your Future guide can be found at 800AGEINFO.com, by accessing the following link:

[www.800ageinfo.com/learncenter.asp?id=178412&sessionid=3-85C3BBDA-D972-4DAA-857E-1CA8F81C0D09&page=72](http://www.800ageinfo.com/learncenter.asp?id=178412&sessionid=3-85C3BBDA-D972-4DAA-857E-1CA8F81C0D09&page=72)



## **Attachment H: 2013 Statewide Needs Assessment Report**

### **Area Agencies on Aging Planners' Needs Assessment Activities September 17, 2012 – December 21, 2012**

Twenty-two Area Agencies on Aging (AAAs) gathered information about the needs of elders from over 4,700 consumers, providers, advocates and stakeholders and staff members who participated in single-and multiple-day events in fall 2012. Vulnerable population participants as well as those with greatest economic and social needs voiced their areas of concerns along with the identification of the top three among all needs.

Transportation is foremost followed by housing and health care. Transportation is .71 times greater than housing and includes three aspects: a) assistance to get around, especially for medical appointments with an escort, and to conduct routine activities and errands, b) infrastructure improvement for more affordable and more public transportation options, and c) service operation improvements such as expanded service hours, service to out-of-geographical service areas for medical appointments, door-to-door service for frail elders who have mobility difficulties, and operators who speak a second language. Foremost regarding housing is more affordable housing and more senior housing options. Financial assistance to help pay for rent/mortgage, heating and utility, property taxes, and maintenance are also essential to help consumers remain in their homes. Specific to health care needs are help with ancillary services especially dental, vision and hearing care due to insufficient funds or high costs and prescription or medication costs.

In preparation for the State and Area Plans on Aging for Federal Fiscal Years 2014 through 2017, planners across 23 Area Agencies on Aging (AAAs) were requested to submit information about needs assessment activities conducted for their specific area plans between September 17, 2012 and December 21, 2012. Using a single sheet reporting form or completing an electronic version of the reporting form, this report presents the summary of the AAA planners' activities. The activities are reported in three sections: Approach and methods used to gather information about elder needs, descriptions of the participants, and areas of concerns including the top three voiced needs.

#### **Approach and methods used to gather information about elder needs**

AAA planners reported on information gathering events conducted between September 17, 2012 through December 21, 2012. In some cases events began before the reporting period or continued after the reporting period. Across 23 AAAs, Table 1 shows events or activities conducted by 22 AAAs. Among the 182 reports submitted, three AAAs also reported using secondary data sources to help identify needs of elders. These AAAs used secondary sources such as the Behavioral Resource Factor Surveillance System (BRFSS) and National Resource Center on LGBT Aging.

With regard to primary data sources, all AAAs conducted single-day, multiple-days or a combination of both to gather information on elders needs. In addition, some AAAs used a combination of methods within the single-day or multiple-day event as shown in Table 2. Labels of events or activities held with consumers included coffee hour, community conversation, forum or meeting, discussion group, focus group, listening session, public gathering, and speak out. All of these labeled sessions were categorized as small public gathering if fewer than 15 participants were in attendance or large public gathering if 15 or more participants were in attendance. The term "interview" includes all sessions reporting in-person, one-on-one, and face-to-face interviews. The term "survey" includes all modes of administration (e.g., hand delivered, mailed and web-based).



**Table 1**  
Approach Used in Gathering Information on Elder Needs

AAA Name	Sources to determine needs			
	Primary data source		Secondary data	Total
	Single day event	Multiple days event		
BayPath Elder Services, Inc.	5	6	0	11
Boston Commission on Affairs of the Elderly	5	0	0	5
Bristol Elder Services	3	3	0	6
Central Mass Agency on Aging, Inc.	8	0	0	8
Chelsea Revere Winthrop Elder Services	4	0	0	4
Coastline Elderly Services	4	6	0	10
Elder Services of Berkshire County, Inc.	3	3	0	6
Elder Services of Cape Cod and the Islands,	6	6	0	12
Elder Services of the Merrimack Valley	0	9	0	9
Franklin County Home Care Corp.	11	0	0	11
Greater Lynn Senior Services, Inc.	5	5	0	10
Greater Springfield Senior Services, Inc.	5	4	0	9
Health & Social Services Consortium, Inc.	5	0	1	6
Highland Valley Elder Services, Inc.	8	0	0	8
Minuteman Senior Services, Inc.	6	0	2	8
Mystic Valley Elder Services, Inc.	8	1	0	9
Old Colony Planning Council	0	3	0	3
SeniorCare, Inc.	7	2	0	9
Somerville-Cambridge Elder Services, Inc.	3	4	0	7
South Shore Elder Services, Inc.	5	3	0	8
Springwell	3	5	7	15
WestMass ElderCare, Inc.	8	0	0	8
<b>Total</b>	<b>112</b>	<b>60</b>	<b>10</b>	<b>182</b>

For single-day events, Table 2 shows that small public gatherings were foremost followed by large public gatherings. Surveys, interviews, and meetings with stakeholders were also used. Single-day events totaled 160 hours (Table 3) and ranged in duration from 25 minutes to 7 hours 45 minutes. Nearly half (48%) of all single-day sessions were 60 or fewer minutes; 94%, 120 minutes or less in duration. One-half of the single-day events were completed in 65 minutes.

**Table 2**  
Methods Used in Gathering Information on Elder Needs

Methods	Single-day event (N=112)	Multiple-day event (N=60)	Total N=172
Interview	10	9	19
Large public gathering (15+ participants)	29	4	33
Public comment	3	0	3
Small public gathering (under 15 participants)	52	0	52
Stakeholder Meeting	9	0	9
Survey	10	54	62
Taskforce/Commission	1	1	2
	<b>114</b>	<b>68</b>	<b>180</b>



**Table 3**  
Duration of Single-day Events

Minutes	Freq	Percent	Cum %
Less than 60 minutes	17	15.2	15.2
60 minutes	37	33.0	48.2
90 minutes	34	30.4	78.6
120 minutes	17	15.2	93.8
Greater than 120 minutes	7	6.3	100.0

Table 4 shows the earliest start time was 8:30 a.m. and the latest 6:00 p.m. More than a third of the sessions started between 10:00 a.m. and 11:00 a.m., with half of all single-day events initiated before 11:00 a.m. Sixty percent were initiated by noon. Only 6% of the session started at 3:00 p.m. or thereafter. In terms of end time, 40%percent of the sessions ended before noon; 65% were completed by 2:00 p.m. and nearly 90% by 4:00 p.m. Only 11% ended 4:00 p.m. or thereafter.

**Table 4**  
Start Time and End Time of Single-day Events

Single-day Event							
Start Time	Frequency	Percent	Cum Percent	End Time	Frequency	Percent	Cum Percent
8:30 - 8:59 a.m.	2	1.8%	1.8%	10:00 - 10:59 a.m.	11	9.8%	9.8%
9:00 - 9:59 a.m.	13	11.6%	13.4%	11:00 - 11:59 a.m.	34	30.4%	40.2%
10:00 - 10:59 a.m.	41	36.6%	50.0%	12:00 - 12:59 p.m.	18	16.1%	56.3%
11:00 - 11:59 a.m.	11	9.8%	59.8%	1:00 - 1:59 p.m.	10	8.9%	65.2%
12:00 - 12:59 p.m.	10	8.9%	68.8%	2:00 - 2:59 p.m.	15	13.4%	78.6%
1:00 - 1:59 p.m.	16	14.3%	83.0%	3:00 - 3:59 p.m.	12	10.7%	89.3%
2:00 - 2:59 p.m.	12	10.7%	93.8%	4:00 - 4:59 p.m.	5	4.5%	93.8%
3:00 - 3:59 p.m.	1	0.9%	94.6%	5:00 - 5:59 p.m.	2	1.8%	95.5%
4:00 - 4:59 p.m.	1	0.9%	95.5%	6:00 - 6:59 p.m.	1	0.9%	96.4%
5:00 - 5:59 p.m.	3	2.7%	98.2%	7:00 - 7:59 p.m.	3	2.7%	99.1%
6:00 p.m.	2	1.8%	100.0%	8:00 p.m.	1	0.9%	100.0%

Administering a survey was the predominate mode with regard to multiple-day events. Seven surveys were administered before the reporting period of September 17, 2012 and six surveys closed after the reporting period of December 21, 2012. Multiple-day events ranged from 3 days to 134 days in duration; one-half were completed in 29 or less days. Ninety percent (54) were closed during the reporting period and 10% (6) closed after the reporting period (i.e., between December 22, 2012 and December 31, 2012).

## Participants

A total of 4,718 participants joined in the single-day (1,723) and multiple-day events (2,995). Consumers were the predominate participants followed by advocates, stakeholders, providers and staff members. Consumers were present in 4 of every 5 events held; advocates and stakeholders in 1 of 5 events, and providers in 1 of every 6 events.





**Table 5**  
Type of Participants

Type of Participant	Single-day event		Multiple-day event		Total	
Consumer	89	79.5%	50	83.3%	140	81.3%
Providers	14	12.5%	15	25.0%	29	16.9%
Advocates & Stakeholders	26	23.2%	7	11.7%	33	19.3%
AAA staff members	12	10.7%	3	5.0%	15	8.8%

The vulnerable population included four types: race/ethnicity, linguistic minority, economic need and social needs. Table 6 shows that non-majority participants as well as persons of Spanish/Latino heritage were present in at least a quarter of all events held.

**Table 6**  
Vulnerable Population Attending or Participating in Need Assessment Events

Vulnerable Population	Single-day event	Multiple-day event	Total	
	Frequency	Frequency	Frequency	Percent
<b>Racial/Ethnic Groups</b>				
Majority	83	49	132	76.7%
Black	28	17	45	26.2%
Native Am/Pacific Islander	7	12	19	11.0%
Asian	20	13	33	19.2%
American Indian	4	4	8	4.7%
Multiracial/Other	28	16	44	25.6%
<b>Spanish/Latino</b>	20	22	42	24.4%
<b>Limited English Proficiency</b>	37	16	53	30.8%
American Sign Language	1	0	1	1.9%
Chinese	9	3	12	22.6%
Greek	0	1	1	1.9%
Haitian Creole	3	2	5	9.4%
Hindi	1	0	1	1.9%
Italian	2	1	3	5.7%
Khmer	1	3	4	7.5%
Korean	1	0	1	1.9%
Polish	10	2	12	22.6%
Russian	3	3	6	11.3%
Spanish	17	14	31	58.5%
Vietnamese	2	1	3	5.7%
<b>Economic Need</b>	75	50	125	72.7%
Low Income	56	44	100	58.1%
Low Income Minority	42	29	71	41.3%



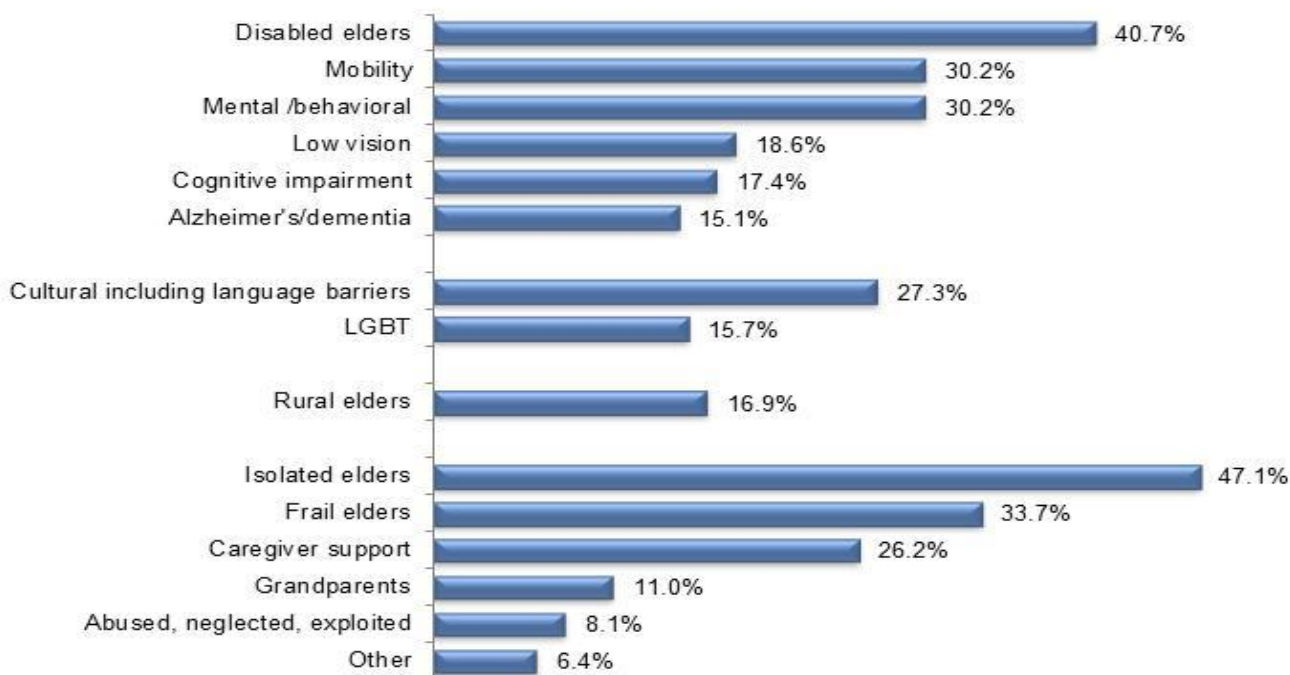
In 31% of the events, elders or advocates and stakeholders representing limited English Proficient elders were present. Twelve languages were identified with elders speaking Spanish, Polish and Chinese the predominant language groups.

The term, “greatest economic need” refers to need resulting from an income at or below the poverty level. Elders with economic need participated in 73% of the events. Low income majority elders were present in 58% of the events; non-majority low income elders in 41% of the events. (Elders with nutrition-meal needs participated in a third of the events.)

The term, “greatest social need” refers to need resulting from noneconomic factors including physical and mental disabilities, language barriers, and cultural, social, or geographical isolation. Figure 1 shows the social needs of participants from the single-and multiple-day events. For elders with physical and mental limitations or disabilities, disabled elders participated in 41% of the events followed by those with mobility, mental/behavioral, low vision, cognitive impairments, and Alzheimer’s/dementia.

Elders facing cultural isolation including those with language barriers and LGBT elders participated in more than a quarter of the events. Elders residing in rural areas participated in 17% of the events. Elders socially isolated (47%) were the prominent participants in the events followed by frail elders, and those needing caregiver support, caring for their grandchildren, and abused, neglected or exploited elders.

**Figure 1**  
Social Needs of Elder Participants



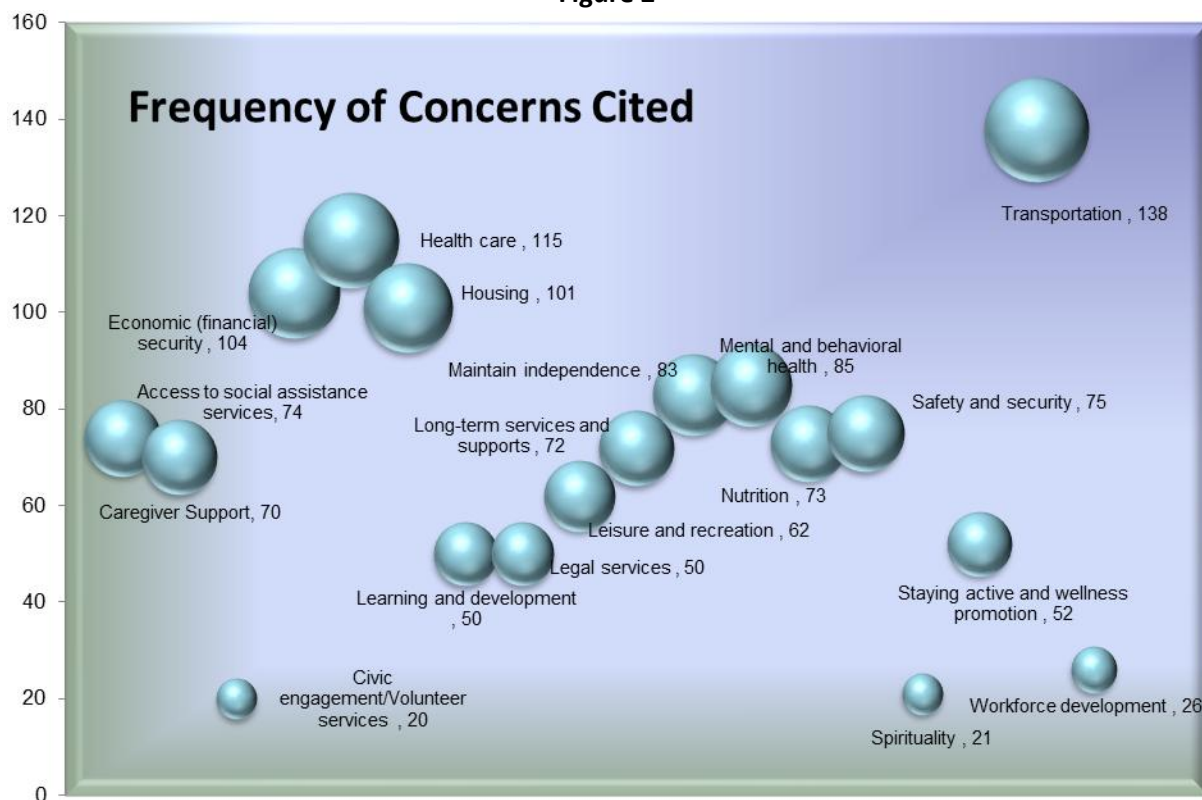
## ELDER AREAS OF CONCERNS

Event leaders from both single-and multiple-day events reported the areas of concerns of participants in their respective sessions. In addition, they indicated the top three from among the voiced areas and elaborated on the area.



From left to right in alphabetical sequence, Figure 2 shows the frequency of times or magnitude of each of the 18 areas cited by participants. The areas are presented in alphabetical sequence from left to right. Cited most often was Transportation (138) and least often, Civic engagement/Volunteer services (20).

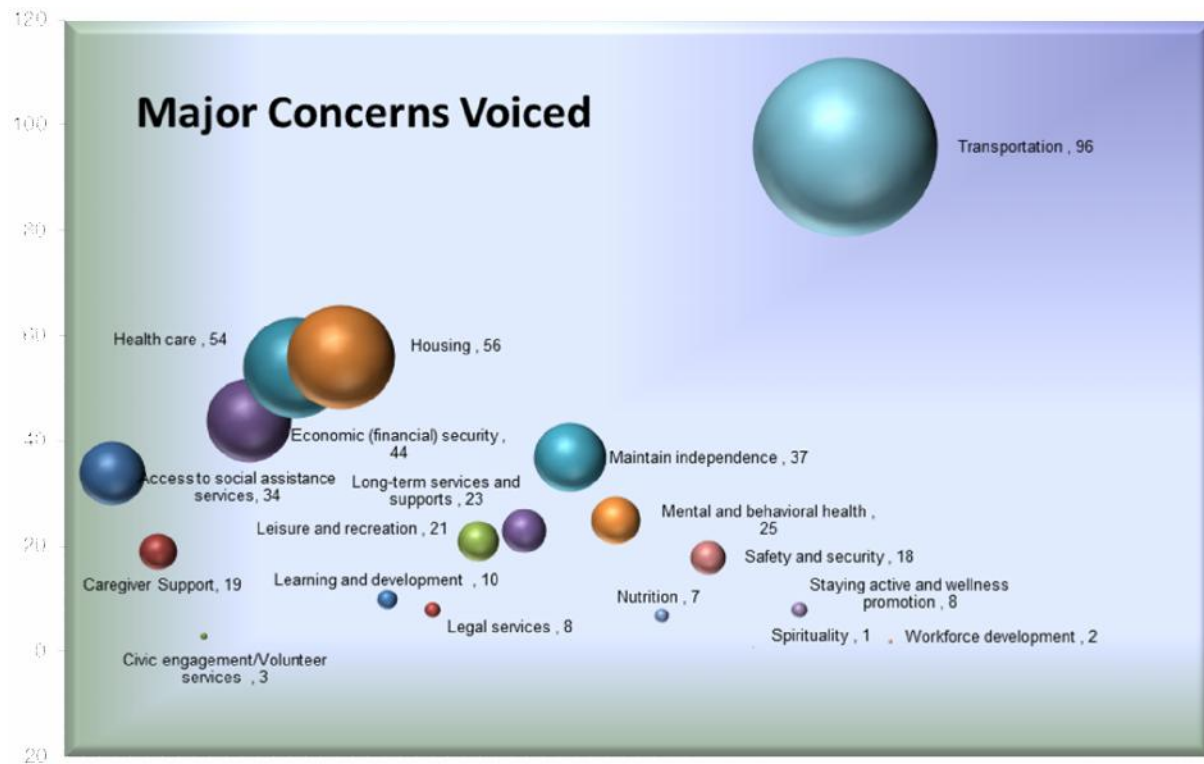
Figure 2



### Three Major Concerns

The top three concerns from among all areas voiced are shown in Figure 3. **Transportation** is foremost followed by housing and health care. Need for transportation is .71 times greater than the second area, housing, and overshadows all other areas of concerns. Transportation consists of three aspects of need: a) assistance to get around especially for medical appointments with an escort and to conduct routine activities and errands (e.g., shopping, bank transactions, personal care appointments, visiting family and friends); b) infrastructure improvements, that is, more affordable and more public transportation options; and c) service operation improvements such as expanded service hours, service to out-of-geographical service areas for medical appointments, door-to-door service for frail elders who have mobility difficulties, and transportation operators who speak a second language.

Figure 3



Regarding **Housing**, foremost are more affordable housing and more senior housing options (e.g., assisted living, supportive housing, retirement community). Elders also voiced the need for financial assistance with housing costs to help pay for rent/mortgage, heating and utility, property taxes, and maintenance. Elder renters voiced need with roommate matching and assistance resolving tenant issues (e.g., cleanliness, pest control, and ventilation). Elder homeowners expressed help with home repairs and maintenance, yard maintenance or landscaping, snow removal, and home modification (akin to universal designed homes).

Specific to **Health care** needs are help with ancillary services especially dental, vision and hearing care due to insufficient funds or high costs. Assistance with prescription or medication costs, need for more health care workers (doctors and nurses), and information on general health and wellness and chronic disease management were also expressed.

Specific needs cited in descending order of frequency for the remaining 15 areas of concerns are listed in Table 7.



**Table 7**  
**Specific Needs of 15 Other Areas of Concerns**

**Economic (financial) security**

- Managing money
- Housing and related costs (insurance, heating/fuel, repairs, property taxes)
- High cost of living
- Paying for food
- Health care related costs including insurance and prescription co-pays
- Paying debts; credit card bills
- Benefit counseling and help accessing benefits
- Financial planning, protecting assets, financial exploitation
- Other (e.g., no funds for emergencies; funds for funerals)

**Maintain independence**

- Home care services
- Affordable home care services
- Snow shoveling; chopping, splitting and carrying wood
- Adaptive equipment
- End of life care
- Information translated so elder can attend function
- More cultural sensitive in-home services
- Availability of Lifeline in home

**Access to social assistance services**

- Information on available benefits, eligibility criteria, and accessing it
- Access to information, services and resources
- Help applying for benefits
- Information on health care costs
- Information on in-home services

**Mental and behavioral health**

- Help with depression, anxiety, and substance/ tobacco abuse
- Loneliness and/or isolation
- Coping w/ memory loss, cognitive impairments
- Funding
- Family counseling
- Homophobia
- Lack of counselors
- Recent loss or grief counseling

**Long term services and supports**

- Home care services
- Culturally competent service providers for LGBT elders
- Long term care planning
- Need for bilingual case manager
- Need English speaking homemakers
- Home care services and funding for disabled people under 60

- Insufficient hours in home care package
- More culturally sensitive in-home services

**Leisure and recreation including socialization**

- More social gathering opportunities
- Social events for LGBT elders
- More diverse options for activities
- Need place to meet to socialize
- Social programs that integrate multiple cultures
- More welcoming meeting area

**Caregiver support**

- Respite care
- Support for caregiver
- Lack of knowledge about resources
- Challenge navigating caregiver network
- Counseling, support and educational programs
- Long distance caregiving

**Safety and Security**

- Home modification/remodeling for safety and accessibility
- Consumer protection (e.g., identify theft, privacy, scams)
- Safe environment- free from physical, mental, financial and sexual abuse and exploitation
- Safer sidewalks -- inaccessible to persons in wheelchairs; inadequate lightening
- Safety in public housing -- security to keep intruders out; emergency procedure in case of bldg. evacuation
- Door to door and door through door, rather than just curb to curb to help elders
- Coordination and communication with town official for emergencies
- More cell phone towers -- no signals and cannot connect in emergencies
- More police presence especially at night and in winter.

**Learning and development )**

- Classes on new technology/computer
- English and citizenship classes
- Broader range of educational programs for seniors
- So much information online -- low vision elders' inability to access information from the computer
- Music classes

**Staying active and wellness promotion )**

- Access to exercise equipment /classes
- Classes on healthy eating
- Classes on increasing balance and preventing falls
- Health education
- Healthy aging workshops
- Managing chronic illness

**Legal services**

- Guardianship and wills
- Health care proxy, medical directives
- Guidance on keeping and sharing information in emergency yet comply with HIPPA
- Court issues

**Nutrition**

- HDM/LGBT community meal important
- Healthy meal preparation
- No grocery stores near homes
- Cost of food increasing

**Civic engagement/volunteer opportunities**

- Limited volunteer opportunities

**Workforce development**

- Few employment opportunities that pay more than low wages
- Training for providers, vendor agencies, senior centers staff and clients on LGBT issues and cultural competency

**Spirituality**

- Lack of faith based activities they had access to

**Other**

- Social isolation of elders
- Need translation services
- Language/communication barrier poses access to services
- Training for COA's and elder services organization in identifying and working with LGBT older adults in a culturally competent manner
- Improvement of public spaces to promote socialization
- Lack of programs for Hispanic elders
- Need new senior center or major repairs/modernization of current facility



# 2013 NEEDS ASSESSMENT SURVEY: MUNICIPAL QUESTIONNAIRE

The report presents the results of service priorities reported by Councils on Aging and corresponding level of importance during the next 3-5 years, scope of four operational services, and whether initiatives were conducted for eight targeted elder groups identified under the Older American Act and the recognition and anticipation of the rapidly growing number of elders.

*April 2013*

Executive Office of Elder Affairs

Research & Data Unit

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## 2013 Needs Assessment Survey Municipal Questionnaire

In preparation for the 2014-2017 State Plan on Aging, the Executive Office of Elder Affairs conducted a survey to ascertain elder needs and how municipalities are serving the rapidly growing senior population. In this endeavor, a web-based questionnaire was emailed to 342 Council on Aging (COA) directors or designees on November 1, 2012 with a requested completion return date on or before November 21, 2012. A reminder notice was sent on November 19, 2012.

The web-based questionnaire (see Appendix A) was divided into three parts. Part A, Service Priorities, sought to garner information about each municipal's current service priorities and their service delivery focus in the next 3-5 years. Part B requested information on four operational programs or service (i.e., transportation, emergency management planning, evidenced-based prevention programs, and strength, flexibility and cardiovascular activities). Part C asked COAs to share an initiative (activity or event) conducted in the past three years pertaining to eight target groups identified under the Older Americans Act of 1965 and an initiative to recognize and anticipate the rapid growth of elders in their communities.

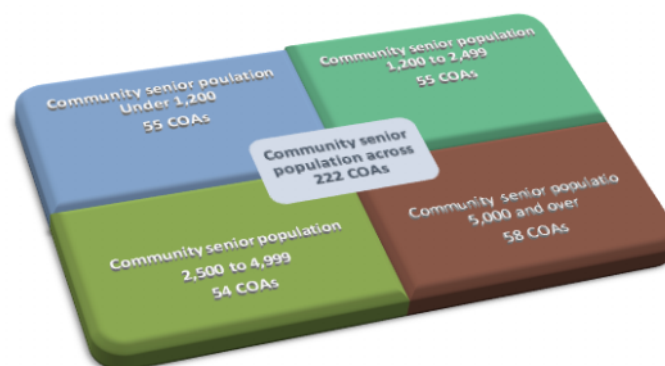
The results of the survey begin with a description of the COA respondents or communities. This is followed by the results under Parts A and B. For Part C, the results for the eight target groups and to recognize and anticipate the rapid growth of elders are reported. Descriptions of the specific initiatives and corresponding major outcomes are summarized in a separate document.

### Description of COA Communities

Responses from 222 COAs, representing 228 municipalities, are included in the survey results. Ninety-eight percent (217) of the COAs are purposed strictly toward their respective communities; 2% (5) have consortia agreements between or among contiguous municipalities for sharing administrative or transportation resources. The 222 COAs represent 66% of the 347 municipalities in the Commonwealth with COAs (see Appendix B).

Based on the U.S. Census Bureau 2010 decennial data, 77% (981,101) of the total 60+ residents in Massachusetts reside in the 222 COAs. The elder population in a community ranges from under 100 to 88,100 in Massachusetts. Given the wide range of the number of elder within a community, COAs fall into four general population groups (Figure 1): 25% are communities with fewer than 1,200 elders, 25% are communities with 1,200 and 2,499 elders, 24% are communities with 2,500 to 4,999 elders, and 26% are communities with 5,000 or more elders.

Figure 4





The COAs are located in all 23 Area Agencies on Aging (AAAs) as shown in Table 1. Forty COAs primarily composed of communities under 1,200 elders are located in three AAAs; 62 COAs with elder population primarily under 2,500 are located in three AAAs, 93 COAs with elder population primarily under 5,000 are located in 11 AAAs, and 27 COAs with elder population of 5,000 or more are located in six AAAs.

Table 7  
NUMBER OF COAS BY ELDER RESIDENT POPULATION SIZE AND AAA

AAA	Under 1,200 elders		1,200 to 2,499 elders		2,500 to 4,999 elders		5,000 or more elders		Total	
	Cnt	Percent	Cnt	Percent	Cnt	Percent	Cnt	Percent	Cnt	Percent
Elder Services of Berkshire County, Inc.	9	69.2%	3	23.1%			1	7.7%	13	100.0%
Franklin County Home Care Corporation*	5	55.6%	3	33.3%	1	11.1%			9	100.0%
Highland Valley Elder Services, Inc.	14	77.8%	2	11.1%	1	5.6%	1	5.6%	18	100.0%
Central Mass Agency on Aging, Inc.*	13	34.2%	17	44.7%	4	10.5%	4	10.5%	38	100.0%
Coastline Elderly Services	1	20.0%	2	40.0%			2	40.0%	5	100.0%
Elder Services of the Merrimack Valley	3	15.8%	7	36.8%	2	10.5%	7	36.8%	19	100.0%
BayPath Elder Services, Inc.	1	9.1%	2	18.2%	6	54.5%	2	18.2%	11	100.0%
Bristol Elder Services	1	8.3%	1	8.3%	6	50.0%	4	33.3%	12	100.0%
Chelsea Revere Winthrop Elder Services					2	100.0%			2	100.0%
Elder Services of Cape Cod and the Islands, Inc.*	5	38.5%	1	7.7%	6	46.2%	1	7.7%	13	100.0%
Greater Lynn Senior Services, Inc.					2	66.7%	1	33.3%	3	100.0%
Greater Springfield Senior Services, Inc.	1	11.1%	3	33.3%	2	22.2%	3	33.3%	9	100.0%
Health & Social Services Consortium, Inc. (HESSCO)			4	40.0%	4	40.0%	2	20.0%	10	100.0%
Minuteman Senior Services, Inc.	2	20.0%	2	20.0%	2	20.0%	4	40.0%	10	100.0%
Old Colony Planning Council			2	14.3%	9	64.3%	3	21.4%	14	100.0%
SeniorCare, Inc.			2	40.0%	1	20.0%	2	40.0%	5	100.0%
WestMass ElderCare, Inc.			2	50.0%	2	50.0%			4	100.0%
Boston Commission on Affairs of the Elderly							1	100.0%	1	100.0%
Mystic Valley Elder Services, Inc.					1	16.7%	5	83.3%	6	100.0%
North Shore Elder Services, Inc.					1	25.0%	3	75.0%	4	100.0%
Somerville-Cambridge Elder Services, Inc.							2	100.0%	2	100.0%
South Shore Elder Services, Inc.			2	25.0%	1	12.5%	5	62.5%	8	100.0%
Springwell					1	16.7%	5	83.3%	6	100.0%
<b>Total</b>	<b>55</b>	<b>24.8%</b>	<b>55</b>	<b>24.8%</b>	<b>54</b>	<b>24.3%</b>	<b>58</b>	<b>26.1%</b>	<b>222</b>	<b>100.0%</b>
*A respondent represents two or more municipalities.										



Across the 222 COAs, 77.1% (981,101) of the total 60+ residents (1,273,217) in Massachusetts reside in the 228 communities (Table 2). While the numbers of COAs are distributed somewhat equally by four community sizes, the resident population numbers are heavily skewed to communities with 5,000 or more elders.

Table 2  
ELDER POPULATION IN COAs BY COMMUNITY SIZE AND AAA

AAA	Elder Population within Community Size				
	Under 1,200	1,200 to 2,499	2,500 to 4,999	5,000 or greater	Total
BayPath Elder Services, Inc.	819	3,542	18,276	19,590	42,227
Boston Commission on Affairs of the Elderly	-	-	-	88,070	88,070
Bristol Elder Services	896	2,267	21,310	41,658	66,131
Central Mass Agency on Aging, Inc.	11,497	30,811	13,399	50,673	106,380
Chelsea Revere Winthrop Elder Services	-	-	8,459		8,459
Coastline Elderly Services	22	3,767	-	26,238	30,027
Elder Services of Berkshire County, Inc.	4,529	5,821	-	10,673	21,023
Elder Services of Cape Cod and the Islands, Inc.	4,715	2,169	23,388	10,857	41,129
Elder Services of the Merrimack Valley	2,366	10,585	6,345	62,406	81,702
Franklin County Home Care Corporation	1,699	6,197	4,070	-	11,966
Greater Lynn Senior Services, Inc.	-	-	6,216	14,483	20,699
Greater Springfield Senior Services, Inc.	363	5,544	7,713	36,919	50,539
Health & Social Services Consortium, Inc. (HESSCO)	-	7,151	16,736	12,515	36,402
Highland Valley Elder Services, Inc.	4,386	3,371	3,505	7,992	19,254
Minuteman Senior Services, Inc.	1,742	3,401	9,345	30,892	45,380
Mystic Valley Elder Services, Inc.	-	-	4,954	38,365	43,319
North Shore Elder Services, Inc.	-	-	4,920	27,666	32,586
Old Colony Planning Council	-	3,354	30,366	33,042	66,762
SeniorCare, Inc.	-	3,761	3,436	15,593	22,790
Somerville-Cambridge Elder Services, Inc.	-	-	-	24,289	24,289
South Shore Elder Services, Inc.	-	4,855	4,334	49,963	59,152
Springwell	-	-	2,746	47,563	50,309
WestMass ElderCare, Inc.	-	3,672	8,834	-	12,506
	33,034	100,268	198,352	649,447	981,101

### Residency of Seniors Partaking in COA Services

As shown in Table 3, elders typically attend a senior center in their respective community. In 3 of every 4 COAs, less than 15% of the seniors who attend a senior center reside in another community (municipality). This behavior is more likely to occur in communities with elder resident population under 1,200 than those in communities with 1,200 or more seniors. In 1 of every 7 COAs, 15% to 24% of elders who attend a senior center reside outside of the community. In about 1 of every 10 COAs, 25% or more the elders who attend a senior center reside in another community.

In communities with less than 1,200 seniors:

- 65% of COAs report that fewer than 5% of seniors reside in another community in contrast to about half the rate (32%-35%) in communities with 1,200 or more elders.
- 19% of the COAs report that 5% to 14% of the seniors reside in another community in contrast to double (38% - 40%) the rate in communities with 1,200 or more seniors.



- 9% of the COAs report that 15% to 24% of the seniors who attend their centers reside in another community in contrast to nearly double (16% -18%) the rate in communities with more than 1,200 seniors.
- 7% of the COAs report that 25% or more of the seniors who attend their centers reside in another community in comparison to 11%-13% in communities with 2,500 or more seniors.

Table 3  
PERCENT OF UNDUPLICATED COUNTS OF SENIORS WHO RESIDE IN ANOTHER COMMUNITY

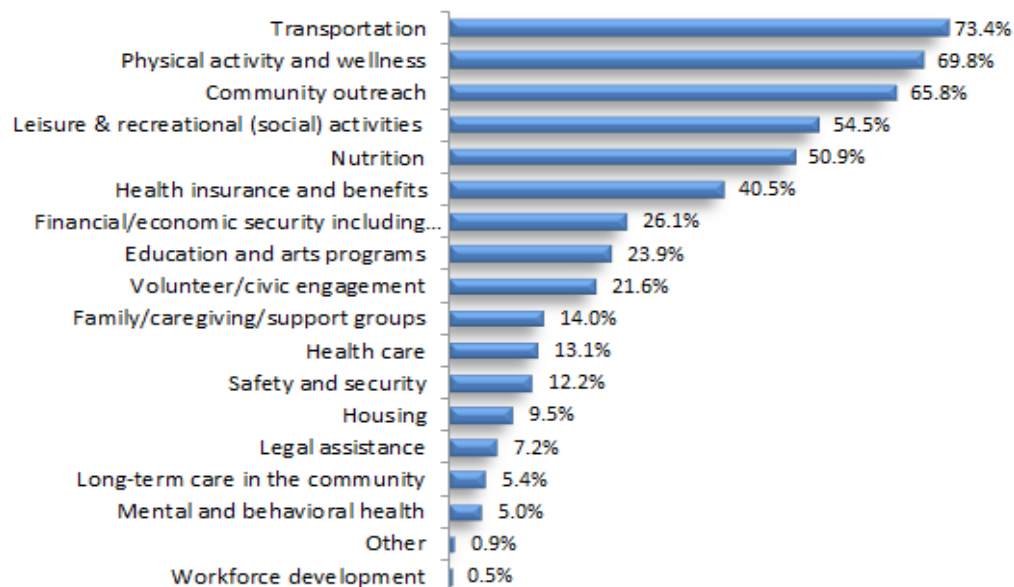
Percent seniors reside in another community	Elder population of community									
	Less than 1,200		1,200 to 2,499		2,500 to 4,999		5,000 or		Total	
	N	%	N	%	N	%	N	%	N	%
Less than 5%	35	64.8%	19	33.9%	17	31.5%	19	32.8%	90	40.5%
5% to 14%	10	18.5%	21	37.5%	21	38.9%	23	39.7%	75	33.8%
15% to 24%	5	9.3%	10	17.9%	9	16.7%	9	15.5%	33	14.9%
25% or greater	4	7.4%	6	10.7%	7	13.0%	7	12.1%	24	10.8%
Total	55	100.0%	55	100.0%	54	100.0%	58	100.0%	222	100.0%
	25%		25%		24%		26%		100%	

## PART A: SERVICE PRIORITIES FOR ELDERS

### Current Service Priorities

Eighteen service areas were listed in the questionnaire to ascertain the service priority areas of COAs. Respondents were asked to indicate the top five their communities are currently focusing on to support elders. Figure 2 presents the service priorities in descending order of priority. The foremost service priority is Transportation (73%) followed by Physical activity and wellness (70%), Community outreach (66%), Leisure and recreational (social) activities (55%), and Nutrition (51%).

Figure 2  
CURRENT SERVICE PRIORITIES OF COAs





With the exception of Health insurance and benefits ranking 5<sup>th</sup> and Nutrition ranking 6<sup>th</sup> for communities with 5,000 or more elders, Table 4 shows that regardless of community size, the five service areas are the priorities across COAs.

Table 4  
SERVICE PRIORITIES BY COMMUNITY SIZE

Rank	Community Size				Statewide
	Under 1,200	1,200 to 2,499	2,500 to 4,999	5,000+	
1	Transportation	Community outreach	Transportation	Physical activity and wellness	Transportation
2	Community outreach	Transportation	Physical activity and wellness	Transportation	Physical activity and wellness
3	Leisure and recreational activities	Physical activity and wellness	Community outreach	Community outreach	Community outreach
4	Physical activity and wellness	Nutrition	Leisure and recreational activities	Leisure and recreational activities	Leisure and recreational activities
5	Nutrition	Leisure and recreational activities	Nutrition	Health insurance and benefits	Nutrition



As shown in Table 5, the number of service priorities in each AAA ranges from five to 16. Across all AAAs, Transportation and Nutrition are cited. With the exception of the Boston Commission on Affairs of the Elderly with 88,100 elders and priorities on housing, legal assistance and long-term care in the community, one or more COA in each AAA cited physical activity and wellness, community outreach, and leisure and recreational activities.

Table 5  
TOP FIVE SERVICE AREAS INDICATED BY COAS WITHIN EACH AAA

AAA	T	PA&W	CO	L&R	N	HI&B	F/ES	E&A	V/CE	FC	HC	S&S	H	LA	LTC	M&BH	O	WD
BayPath Elder Services, Inc.	7	10	7	6	3	4	5	6	5	2								
Boston Commission on Affairs of the Elderly	1				1								1	1	1			
Bristol Elder Services	6	9	7	6	4	9	4	1	2		3		3	1	3	2		
Central Mass Agency on Aging, Inc.	30	26	27	18	28	11	11	6	7	4	6	6	3	4	3			
Chelsea Revere Winthrop Elder Services	1	2	1	2	1	1		1		1								
Coastline Elderly Services	3	1	4	2	2	1	1	2		1	2	3	1		1	1		
Elder Services of Berkshire County, Inc.	10	8	10	9	6	4	2	3	3		1	1	1					
Elder Services of Cape Cod and the Islands, Inc.	9	9	10	7	5	7	4	1	2	3	3	1	1	2		1		
Elder Services of the Merrimack Valley	13	14	15	9	7	7	7	6	2	3	2	4	2	1		2	1	
Franklin County Home Care Corporation	4	6	3	7	6	4	1	3	2		1	3						
Greater Lynn Senior Services, Inc.	1	3	1	2	3	1	1	1	1	1								
Greater Springfield Senior Services, Inc.	6	6	6	6	7	5		1	3		1		1		1			1
Health & Social Services Consortium, Inc. (HESSCO)	9	5	9	4	3	6	4	1	1	3		1	1	2		1		
Highland Valley Elder Services, Inc.	11	9	15	15	8	7	2	3	4	3	6	5	2					
Minuteman Senior Services, Inc.	10	7	4	4	3	2	2	6	3	3	2	1	1			1	1	
Mystic Valley Elder Services, Inc.	5	6	1	3	3	2	2	2	2				1	2	1			
North Shore Elder Services, Inc.	4	3	1	2	4	3		1	1		1							
Old Colony Planning Council	10	10	8	4	9	8	6	3	5	2			1	2	2			
SeniorCare, Inc.	3	3	4	5	2	1	1	2		1	1	1	1					
Somerville-Cambridge Elder Services, Inc.	2	2	1	1	1		1						1			1		
South Shore Elder Services, Inc.	8	7	6	4	2	4	2	2	1	3				1				
Springwell	6	6	5	2	1	2	1	2	2	1		1				1		
WestMass ElderCare, Inc.	4	3	1	3	4	1	1		2							1		
Key:																		
T=Transportation	FC=Family caregiving/support groups																	
PA&W=Physical activity and wellness	HC=Health care																	
CO=Community outreach	S&S=Safety and security																	
L&R=Leisure and recreational activities	H=Housing																	
N=Nutrition	LA=Legal Assistance																	
HI&B=Health insurance and benefits	LTC=Long-term care in the community																	
F/ES=Financial/economic security	M&BH=Mental and behavioral health																	
E&A=Education and arts program	O=Other																	
V/CE=Volunteer/civic engagement	WD=Workforce development																	





## Service Delivery Focus in the Next 3-5 Years

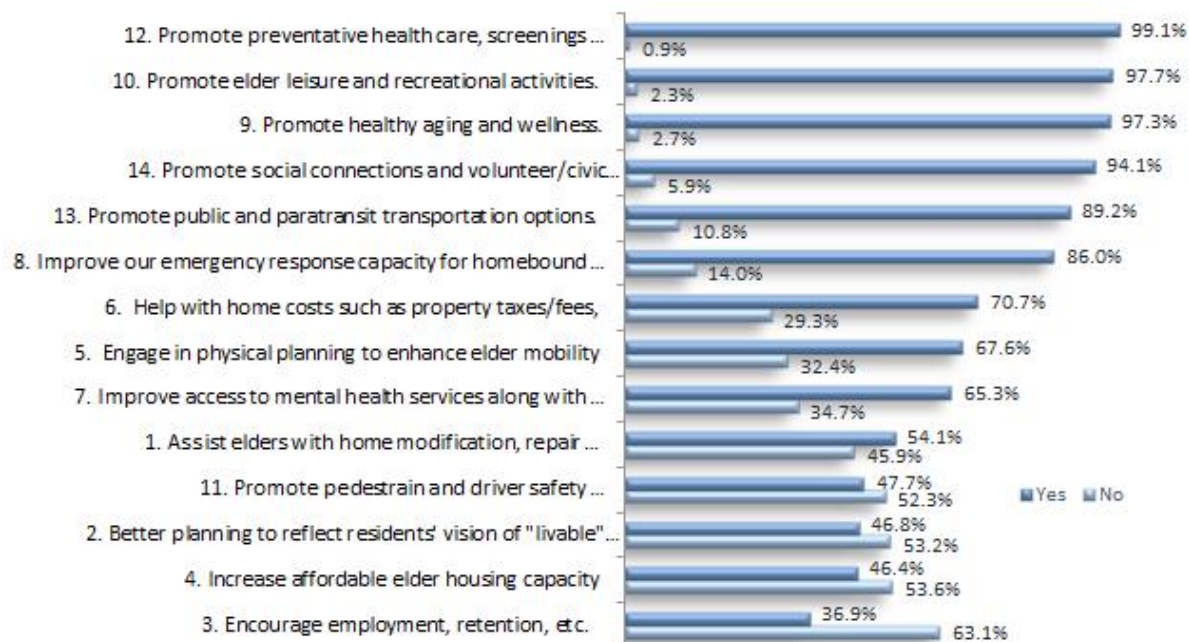
COAs were asked to indicate (Yes/No) if each of 14 initiatives is currently being addressed and to also rate how important the initiative will likely be for the COA in the next 3-5 years.

### Initiative currently being addressed

Figure 3 shows that nearly all COAs reported promoting preventative health care, screenings and immunization, elder leisure and recreational activities, and healthy aging and wellness.

- A full majority (more than 85%) of the COAs reported promoting social connections and volunteer/civic engagement, public and paratransit transportation options, and the improvement of their emergency response capacity for homebound and adult disabled residents.
- Roughly two of every three (65%-71%) COAs report assisting elders with benefit navigation for home costs such as property taxes/fees, water/sewer, home utility, and cable/internet/phone bills, being engaged in physical planning to enhance elder mobility, and improving access to mental health services.
- More than half (54%) of the COAs are assisting elders with home modification, repair and maintenance services.
- Less than half (37%-48%) of the COAs are promoting pedestrian and driver safety in the community, promoting better planning to reflect residents' vision of "livable" communities, increasing affordable elder housing capacity, and encouraging employment retention, training/retaining and recruitment of older workers.

Figure 3  
SERVICE DELIVERY INITIATIVES CURRENTLY BEING ADDRESSED





### Level of importance during the next 3-5 years

For the same 14 service delivery initiatives, respondents indicated their level of importance for the next 3-5 years by marking *Much less important, Somewhat less important, Same importance/No change, Somewhat more important, or Much more important*). The Likert scale was converted to a weighted score, 0.0, 3.5, 5.0, 7.5 and 10.0, respectively. Table 6 shows the mean score differences between COAs currently addressing and not addressing each initiative.

- With the exception of *promoting leisure and recreational activities*, COAs that currently address a specific initiative have a higher mean score than their counterparts who do not currently address the initiative.
- The largest mean score gap between COAs currently addressing and not currently addressing an initiative occurs for *help with home costs* (item 6); the smallest mean difference occurs for *assisting elders with home modification, repair and maintenance services* (item 1).

Table 6  
MEANS, STANDARD DEVIATIONS, AND ONE-WAY ANALYSES OF VARIANCE (ANOVA)  
FOR LEVEL OF IMPORTANCE PERTAINING TO 15 INITIATIVES

Means, Standard Deviations, and One-Way Analyses of Variance (ANOVA) for Level of Importance Pertaining for 14 Initiatives					
Initiative	Initiative currently being addressed by COAs				
	Yes		No		ANOVA
	M	SD	M	SD	F(1,220)
1. Home modification	6.31	2.149	6.20	2.456	0.130
9. Healthy aging and wellness	7.67	2.003	6.67	1.291	1.496
10. Leisure and recreational activities	6.68	1.982	7.00	2.092	0.126
12. Preventative health care	6.70	2.011	5.00	3.536	1.410
4. Elder housing capacity	8.06	1.817	6.43	3.046	22.539**
13. Public and paratransit options	7.87	2.005	5.94	3.281	16.845**
8. Emergency response capacity	7.68	2.044	6.45	2.215	9.461*
5. Enhance elder mobility	7.67	1.705	6.08	2.132	35.795**
6. Help with home costs	7.53	1.940	4.92	2.794	63.32**
7. Access to mental health	7.52	1.943	5.88	2.492	29.318**
14. Social connection and civic engagement	6.94	1.854	4.62	2.670	18.136**
2. Better planning... "livable" community	6.88	1.994	5.66	2.724	14.131**
3. Employment retention	6.77	1.821	5.02	2.837	25.127**
11. Pedestrian and driver safety	6.65	1.886	5.67	2.785	9.301*
*p < .01. **p < .001.					

Of these 14 initiatives, moderate program development from nearly all COAs will continue to occur during the next 3-5 year for the following:

- Promoting healthy aging and wellness
- Promoting leisure and recreational activities
- Promoting preventative health care, screenings and immunizations

For COAs currently addressing the following, robust program development will likely occur during the next 3-5 years in contrast to little changes from COAs not currently addressing these initiatives.

- Increase affordable elder housing capacity



- Promote public and paratransit transportation options
- Improve the emergency response capacity for homebound and adult disabled residents
- Engage in physical planning to enhance elder mobility
- Assist with home costs
- Improve access to mental health services

For COAs currently addressing the following, moderate program development will likely occur during the next 3-5 years in contrast to little or no changes from COAs not currently addressing these initiatives.

- Promoting social connection and civic engagement in the community
- Better planning to reflect residents' vision of livable community
- Encouraging employment retention, training/ retraining and recruitment of older workers
- Promoting pedestrian and driver safety

Finally across COAs, little program development changes are projected to occur during the next 3-5 years for assisting elders with home modification, repair and maintenance services.

## PART B: FOUR OPERATIONAL SERVICES

### Transportation

Eighty-three percent (185) of the COAs use paratransit or other services (e.g., vans, muni buses, private cars) to transport elders and persons with mobility limitations. Table 7 shows that communities with 1,200 or more elder population are more likely to offer transportation services than communities with under 1,200 elder residents ( $\chi^2 = 18.249$ ,  $df = 3$ ,  $p < .001$ ).

Table 7  
USE PARATRANSIT OR OTHER SERVICE MODE TO TRANSPORT ELDERS  
AND PERSONS WITH MOBILITY LIMITATIONS BY COMMUNITY SIZE

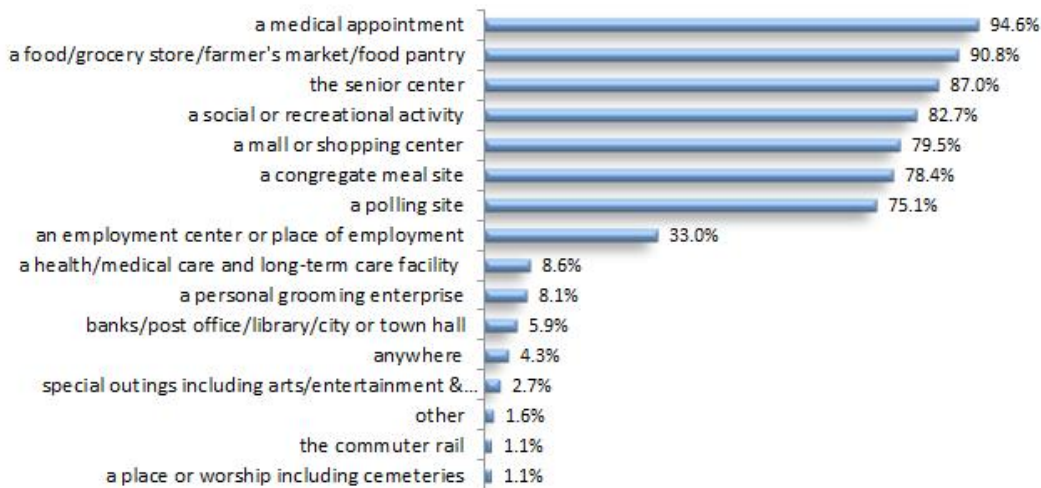
Use paratransit or other service vehicle	Community size				
	Under 1,200 elders	1,200 to 2,499 elders	2,500 to 4,999 elders	5,000 or more elders	Total
Yes	35 64.8%	49 87.5%	50 92.6%	51 87.9%	185 83.3%
No	19 35.2%	7 12.5%	4 7.4%	7 12.1%	37 16.7%
Total	54 100.0%	56 100.0%	54 100.0%	58 100.0%	222 100.0%

### Places elders transported

As shown in Figure 4, COAs primarily transport elders and persons with mobility limitations to seven places or activities: a medical appointment, a food/grocery/farmer's market or food pantry, a senior center, a social or recreation activity, mall or shopping center, a congregate meal site, and a polling site.



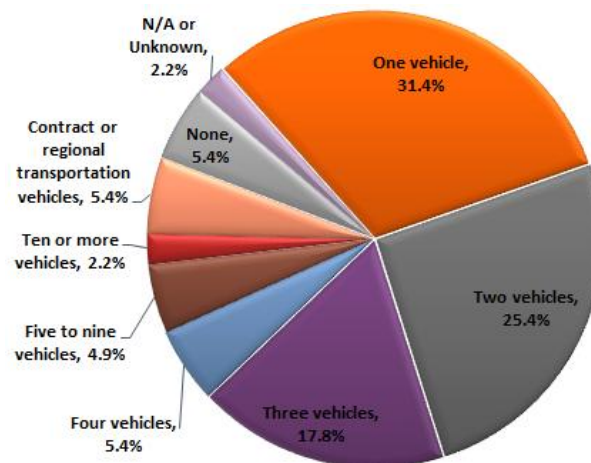
Figure 4  
PLACES OR ACTIVITIES PARATRANSIT VEHICLES TRANSPORT ELDERS  
INCLUDING PERSONS WITH MOBILITY LIMITATIONS



#### Number of transport vehicles

As shown in Figure 5, nearly 1 of every 3 COA uses one vehicle to transport elders and individuals with mobility limitations. One in four uses two vehicles, and nearly 1 in 5 uses three vehicles. Collectively, 3 of every 4 COAs report using between one and three vehicles to transport elders and individuals with mobility limitations. Only 1 of every 8 uses more than four vehicles and 1 in 20 contract or use regional transportation vehicles.

Figure 5  
NUMBER OF VANS, BUSES, AND MINI BUSES  
USED BY THE SENIOR CENTERS TO TRANSPORT ELDERS



#### Estimated counts of elders transported in SFY 2012

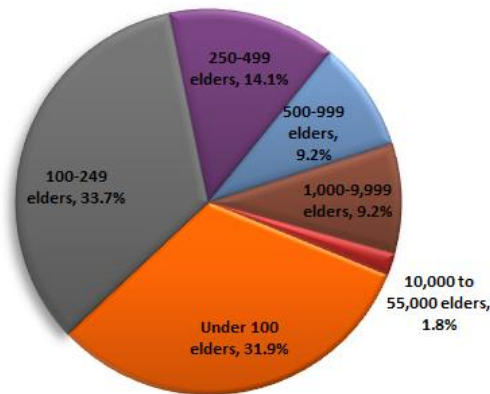
Based on 163 COAs that reported an unduplicated (and in some cases estimated) count of elders transported in SFY 2012, a total of 152,900 elders were transported from their residence to one or more places. The estimated counts of seniors transported annually by senior centers' paratransit or other service vehicles range in number from under 100 to 55,000.

Shown in Figure 6, nearly 1 of 3 senior centers transport less than 100 elders and persons with mobility limitations annually, 1 of 3 transports between 100 and 249 elders, and nearly 1 of 4 transports



between 250 and 999 elders. About 1 in 10 transports more than 1,000 elders annually. The median number of elders transported is 180.

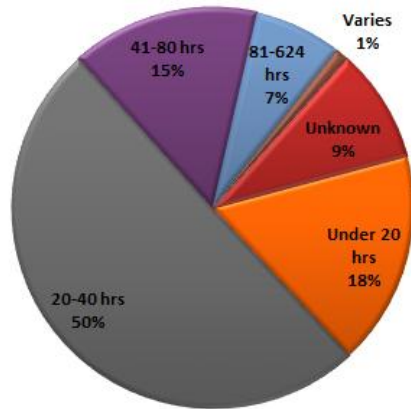
Figure 6  
ESTIMATED COUNTS OF ELDERS TRANSPORTED IN SFY 2012



Total hours vehicles are on the road

Total weekly hours vehicles are on the road range from under 20 hours to 624 hours. Figure 7 shows that in half the communities, vehicles were on the road 20-40 hours a week. Vehicles on the road under 20 hours each week were next (18%) followed by vehicles on the road for 41-80 hours a week (15%), and vehicles were on the road 81 or more hours a week or by appointment (8%). About 1 in 10 COAs did not know the amount of hours their vehicles were on the road weekly.

Figure 7  
TOTAL HOURS A WEEK VEHICLES ARE ON THE ROAD

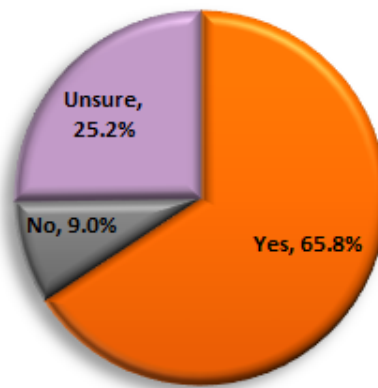


**Emergency Management Planning**

Among the 222 COAs, Figure 8 shows that nearly 2 of every 3 COAs reported that their communities maintained a registry or record of people who require additional assistance to respond to emergencies. One of every 4 COAs was unsure if a registry was maintained and about 1 of every 10 did not maintain a registry.

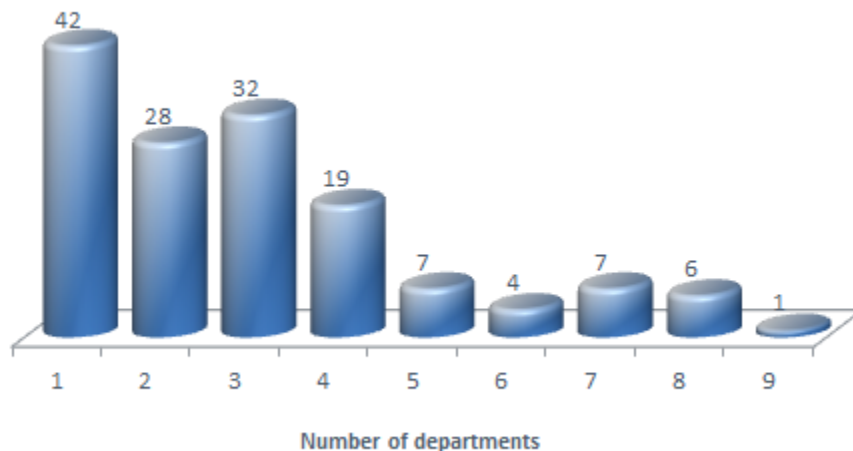


Figure 8  
COAs MAINTAIN A REGISTRY OF PEOPLE WHO REQUIRE ADDITIONAL ASSISTANCE



Among 146 communities that maintained a registry, Figure 9 shows that 29% (42) indicated a single department was responsible to maintain and update the registry, 54% (79) reported 2-4 departments, and 17% (25) cited 5 to 9 departments.

Figure 9  
NUMBER OF DEPARTMENTS RESPONSIBLE  
FOR MAINTAINING AND UPDATING THE REGISTRY



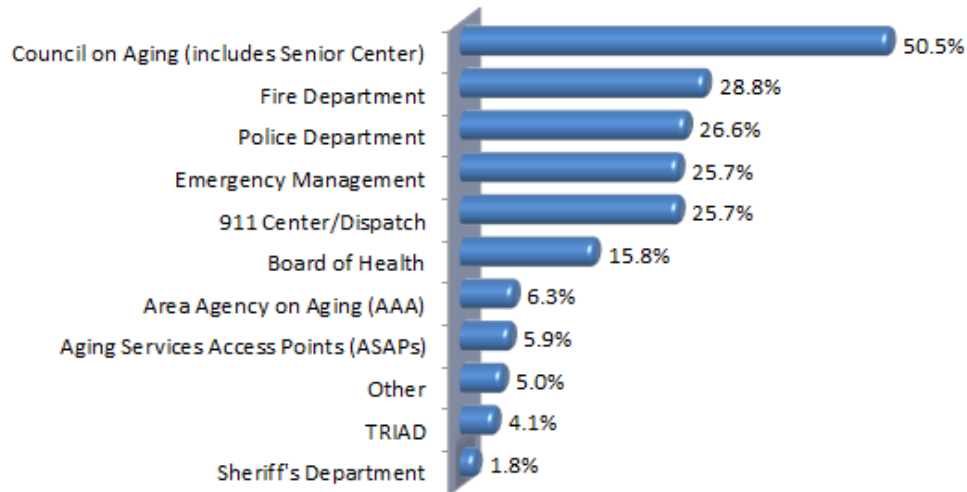
#### Municipal Department(s) Responsible to Maintain Registry

As shown in Figure 10, the COA is cited most often (51%) as the municipal department responsible to maintain and update the registry. Other municipal departments cited are the Fire department (29%), Police department (27%), Emergency Management (26%), and 911 Center/Dispatch.





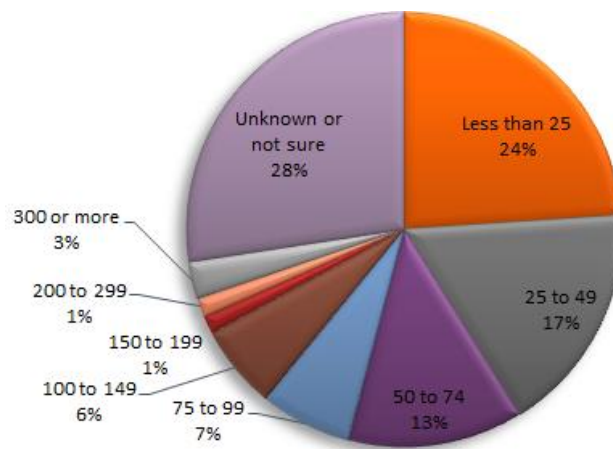
Figure 10  
DEPARTMENT RESPONSIBLE FOR MAINTAINING AND UPDATING THE REGISTRY



#### Number of People Who Require Additional Assistance

With regard to the number of people currently registered, Figure 11 shows that the numbers are roughly in four groups: 24% of the COAs have less than 25 people registered, 30% have between 25 and 74 people registered, and 18% report 75 or more people registered. Twenty-eight percent report that they do not know how many people are registered with their respective municipality.

Figure 11  
NUMBER OF PEOPLE REGISTERED AS OF JULY 2012



#### Frequency COA Meets with Other Municipal Departments

COAs were asked to report on how often they met with eight other municipal departments during a 12-month period. In terms of frequency, respondents were asked to mark monthly, every other month, quarterly, biannually or annually. Not applicable would be indicated if the COA did not meet with the department or said department did not exist.

Among 113 COAs that responded, Police, Fire and Public Health departments were present in more than 90% of the communities. A Veterans department was present in 85% of the communities, an EMS in





79% of the communities, Parks & Recreation in 69%, Housing in 63%, and Human Services in half the communities. Although the presence or absence of the eight departments varied across communities, COAs typically met with other departments on a monthly basis (Table 8). For all but the Housing department, quarterly meetings were the next commonly held sessions followed by every other month, biannual or annual basis.

Table 8  
FREQUENCY COA MEETS WITH EACH MUNICIPAL DEPARTMENT

Department	Monthly		Every other month		Quarterly		Biannually		Annually		Total	
Police	72	66.1%	7	6.4%	21	19.3%	6	5.5%	3	2.8%	109	100.0%
Fire	64	59.8%	6	5.6%	24	22.4%	7	6.5%	6	5.6%	107	100.0%
Public Health	66	64.1%	8	7.8%	19	18.4%	5	4.9%	5	4.9%	103	100.0%
Veterans	53	55.2%	9	9.4%	20	20.8%	8	8.3%	6	6.3%	96	100.0%
EMS	47	52.8%	4	4.5%	17	19.1%	10	11.2%	11	12.4%	89	100.0%
Parks & Recreation	36	46.2%	5	6.4%	22	28.2%	6	7.7%	9	11.5%	78	100.0%
Housing	23	32.4%	10	14.1%	16	22.5%	5	7.0%	17	23.9%	71	100.0%
Human Services	34	60.7%	7	12.5%	10	17.9%	1	1.8%	4	7.1%	56	100.0%

### Evidenced-Based Programs

As defined by the Administration for Community Living (ACL), “evidenced based prevention programs are interventions...that have been proven effective in reducing the risk of disease, disability, and injury among elders.” Three evidence-based programs emphasized by ACL are Chronic Disease Self-Management Program, Healthy Eating for Successful Living in Older Adults and A Matter of Balance.

Table 9 shows the number of COAs that offered these evidenced-based programs and the number of times the program was offered in their communities in SFY 2012. Leading the way is Healthy Eating for Successful Living in Older Adults followed by A Matter of Balance and Chronic Disease Self-Management Program. One of 3 COAs offered Health Eating for Successful Living in Older Adults three or more times, 1 of 4 COAs offered A Matter of Balance three or more times, and 1 of 5 COAs offered Chronic Disease Self-Management Program three or more times.

- 43% (95) of the communities offered Chronic Disease Self-Management Program
  - 81% (77) offered the program once or twice during the past 12 months.
  - 19% (18) offered the program three or more times during the past 12 months.
- 55% (123) of the communities offered Healthy Eating for Successful Living in Older Adults
  - 67% (82) offered the program once or twice during the past 12 months.
  - 33% (41) offered the program three or more times during the past 12 months.
- 48% (107) of the communities reported offering A Matter of Balance
  - 74% (79) offered the program once or twice during the past 12 months.
  - 26% (28) offered the program three or more times during the past 12 months.



Table 9  
THREE EVIDENCED-BASED PROGRAMS EMPHASIZED  
BY THE ADMINISTRATION FOR COMMUNITY LIVING

Number of times	Chronic Disease Self-Management Program		Healthy Eating for Successful Living in Older Adults		A Matter of Balance	
	95	42.8%	123	55.4%	107	48.2%
	Count	Percent	Count	Percent	Count	Percent
1	53	55.8%	54	43.9%	46	43.0%
2	24	25.3%	28	22.8%	33	30.8%
3	6	6.3%	15	12.2%	4	3.7%
4	5	5.3%	10	8.1%	2	1.9%
5	1	1.1%	3	2.4%	0	0.0%
6 or more	6	6.3%	13	10.6%	22	20.6%

Eighty COAs also listed other evidenced-based fall prevention programs that were offered from daily to once a year at their respective senior centers.

- 11 (18%) COAs cited specific programs (i.e., Bone Builders; Fewer Falls, Safer Seniors Program) or classes on arthritis or osteoporosis offered twice a week or a 6-week, 7-week or 24-week session.
- 35 (44%) COAs listed informational sessions on fall prevention primarily offered by VNAs once a year.
- 15 (19%) COAs listed classes or sessions on balance including tai chi and yoga which are considered evidenced-based programs that helps to prevent falls.
- 9 (11%) COAs indicated weekly classes or session on endurance such as Zumba, walking, etc.
- 15 (19%) listed programs other than fall prevention (e.g., Diabetes Self-Management, Powerful Tools for Caregivers) and primarily offered on an annual basis.

### Strength, Flexibility and Cardiovascular Activities

#### Physical activity programs

According to the Centers of Disease Control and Prevention, regular physical activity is participation in three or more 20-minute sessions per week that makes the person sweat or five or more 30 minute sessions of slower activity such as walking.

Across 220 COAs, more than 9 of every 10 communities sponsored or offered physical activity programs in the past 12-18 months. When asked to list the FIVE most popular types of strength, flexibility and cardiovascular activities, endurance is at the forefront followed by balance, muscular strengthening, flexibility and stretching (Table 10).



Table 10  
FIVE MOST POPULAR PHYSICAL ACTIVITIES OFFERED BY COAS

Area	Activity	Weighted	
<b>Endurance</b>	Aerobics	65.0	275.2
	Dancing	55.6	
	Exercise/fitness unspecified class	40.2	
	Walking	34.0	
	Zumba/Zumba gold	45.2	
	Water exercises	8.4	
	Wii	23.6	
	Other	3.2	
<b>Balance</b>	Yoga	106.6	183.2
	Taichi	66.8	
	Pilates	3.0	
	Qigong	3.4	
	Better Balance	0.8	
	Balance training	1.2	
	Balance (generic)	1.4	
<b>Muscular strengthening</b>			44.8
<b>Flexibility &amp; Stretching</b>			42.2
<b>Specific program</b>	Better Bones	1.0	27.8
	Arthritis exercise program	6.6	
	Muscles in Motion	1.0	
	Young at Heart Strength Training	1.0	
	Bone Builders	3.4	
	Osteo prevention	13.0	
	Arthritis Association	0.6	
	A Matter of Balance	0.8	
	Fit 4 Life	0.4	
<b>Other</b>			2.2

#### Fitness equipment

Across 201 COAs, 35% (70) reported having fitness equipment in their senior centers.

- 45 have a treadmill
- 31 have resistance bands including therma bands
- 28 have a stationary or an upright bicycle
- 21 have a recumbent bicycle
- 21 have an elliptical machine
- 24 have weights or free weights
- 7 have stability or balance balls

Five or fewer centers have a weight machine, a free weight bench, strength/fitness machine, recumbent cross trainer, Wii, rowing machine, cardio stepper, and a glider and leg press.

Other than hand weights, the five fitness equipment most in use are:

- Treadmill
- Upright or recumbent bicycles
- Resistance bands
- Weights
- Elliptical machine

## PART C: INITIATIVES TO ADDRESS TARGETED GROUPS IDENTIFIED IN THE OLDER AMERICANS ACT AND THE RAPIDLY GROWING SENIOR POPULATION

### Eight Targeted Groups Identified Under the Older Americans Act

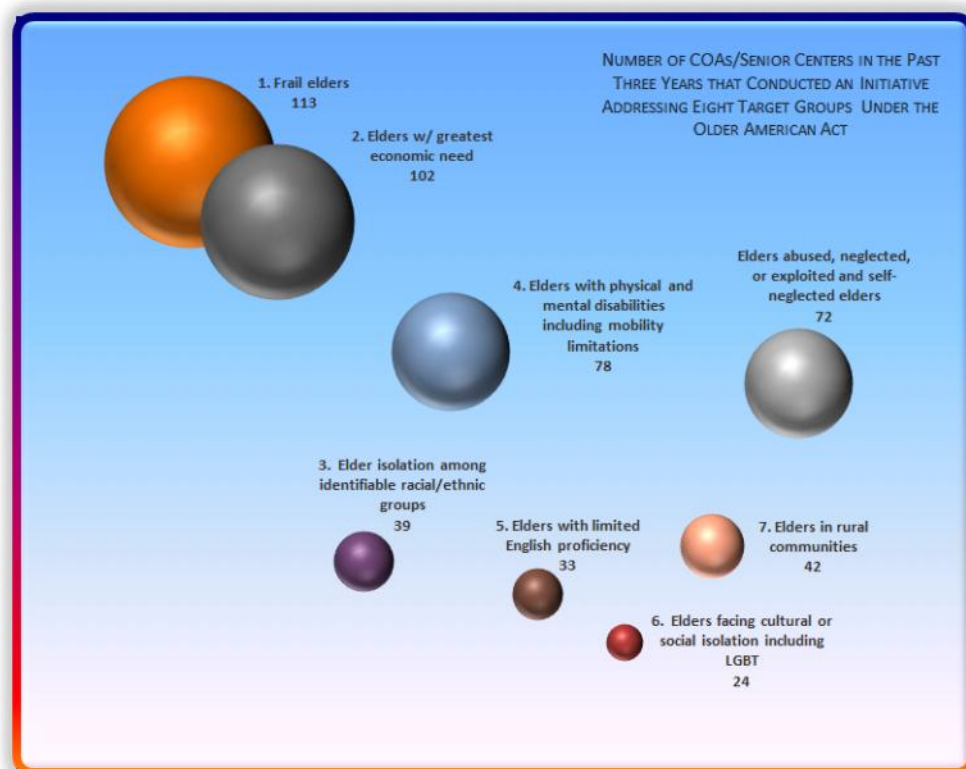
The Older Americans Act of 1965 identifies eight elder groups to be served. These are:

1. Frail elders
2. Elders with greatest economic need (resulting from an income level at or below the poverty level)
3. Elder isolation among identifiable racial or ethnic groups
4. Elders with physical and mental disabilities including mobility limitations
5. Elders with limited English proficiency
6. Elders facing cultural or social isolation including lesbian, gay, bisexual, and transgender (LGBT) individuals
7. Elders in rural communities
8. Elders abused, neglected, or exploited and self-neglected elders

Figure 12 shows the number of COAs that conducted an activity or event in the past three years addressing a target area. Across the 222 COAs, more than half (51%, 113) offered an activity or event pertaining to frail elders. This is followed by events addressing elders with greatest economic need (46%, 102), elders with physical and mental disabilities (35%, 78), and elders abused, neglected or exploited and self-neglected elders (32%, 72).

Less than one in five COAs held activities or events for elder isolation among identifiable racial or ethnic groups (18%, 30), elders with limited English proficiency (15%; 33), and elders in rural communities. The least number of events held were for elders facing cultural or social isolation including LGBT (11%, 24).

Figure 15

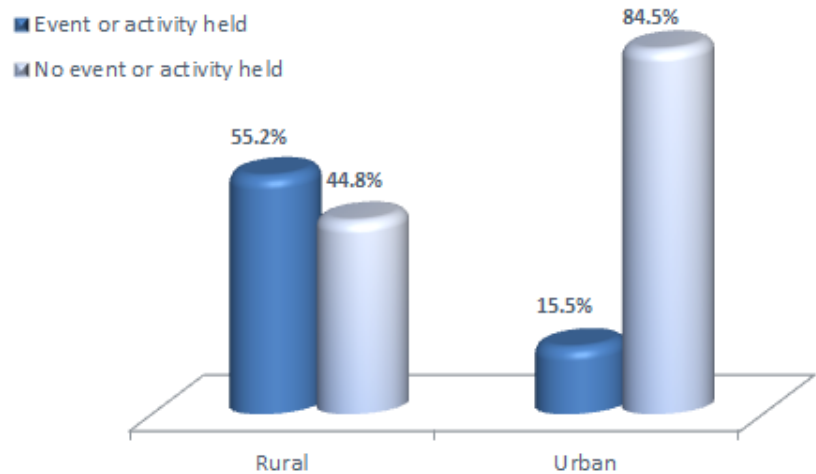




Elder in rural communities

From among 29 COAs classified rural communities (i.e., less than 100 people per square mile), Figure 13 shows that 55% held an event for this targeted group. From among 168 COAs classified urban, 16% also held an event or activity to address elders in rural communities.

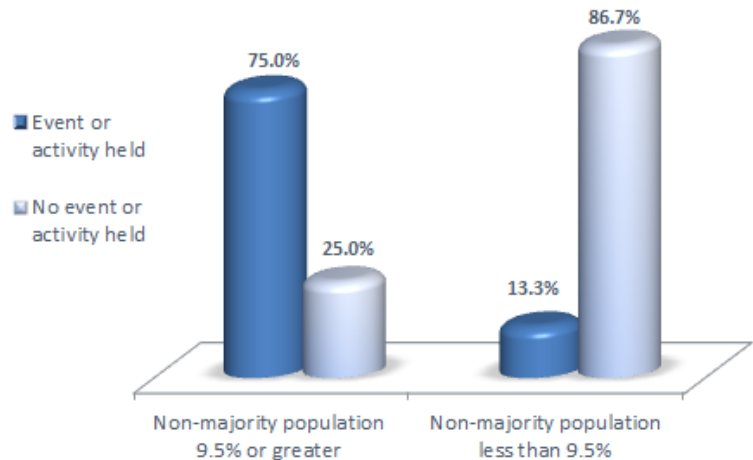
Figure 13  
AN EVENT OR ACTIVITY HELD TO ADDRESS ELDERS IN RURAL COMMUNITIES



Elder isolation among identifiable racial/ethnic groups

Figure 12 shows 39 activities or events were held for elder isolation among identifiable racial/ethnic groups. However, when examined by communities with non-majority elder population that equals or is greater than the state average of 9.5%, Figure 14 shows that 75% of the 20 communities with 9.5% or greater non-majority elder population and 13.3% of 181 communities with less than 9.5% non-majority elders population held an activity for elder isolation among identifiable racial/ethnic groups.

Figure 14  
AN EVENT OR ACTIVITY HELD TO ADDRESS ELDER ISOLATION  
AMONG IDENTIFIABLE RACIAL/ETHNIC GROUPS

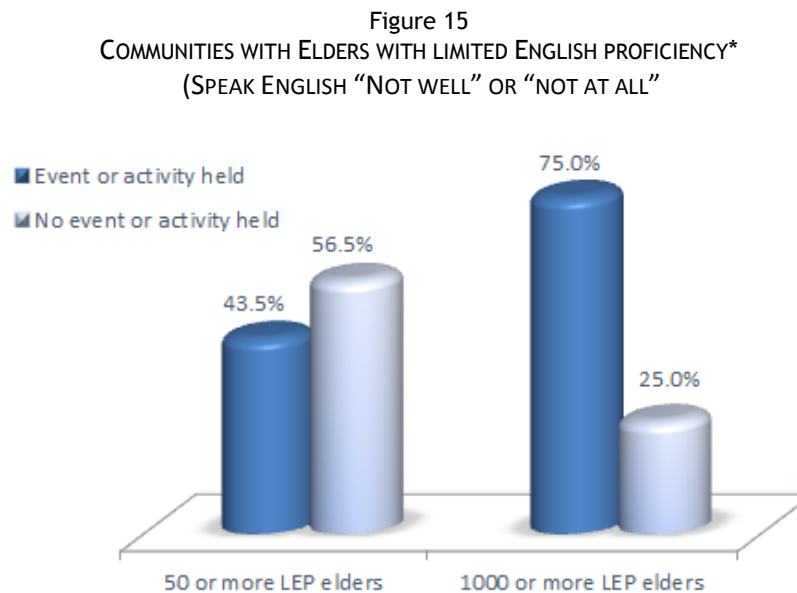




## Elders with limited English proficiency (LEP)

Figure 12 shows 33 activities or events held for elders with limited English proficiency or LEP (defined as people whose first language is not English and speaks English “less than well” or “not at all”). Based on the 2007-2011 5-Year American Community Survey, 62 communities in Massachusetts had 50 or more elder LEPs; 12 communities had 1000 or more elders LEPs.

Figure 15 shows that for communities with 50 or more and 1,000 or more LEP elders, 44% and 75% of the COAs, respectively, held an activity or event for LEP elders.

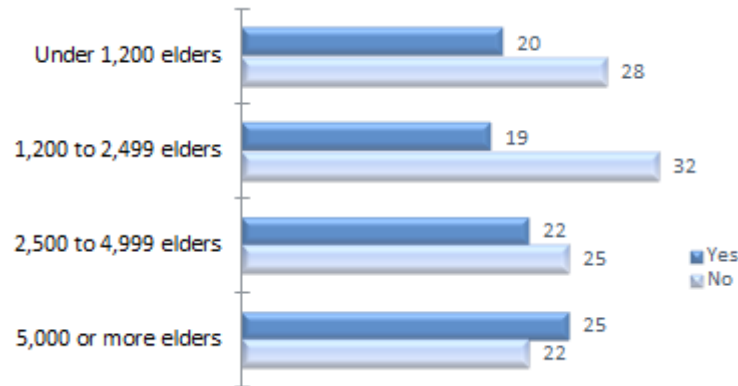


Written translation of vital documents for each language group within a community that constitutes *five percent or 1,000, whichever is less*, if needed, can be provided orally. Alternately, if there are fewer than 50 persons in a language group that reaches the five percent trigger, LEP speakers may be informed that competent oral interpretations of the written materials are available, free of cost.

## Rapidly Growing Senior Population

One hundred ninety-three COAs reported on this initiative. Less than half (47%) of the COAs held an event to recognize and anticipate the rapid growth of elders in their respective community. By community size (Figure 16), only COAs with 5,000 or more elders outnumbered their COA counterparts by holding an event or activity. Community size, however, is not a factor in holding or offering an event to anticipate the rapid growth of elders in the community ( $\chi^2 = 2.778$ ,  $df=3$ ,  $p < .427$ ).

Figure 16  
COA/SENIOR CENTER CONDUCTED AN INITIATIVE IN THE PAST THREE YEARS TO RECOGNIZE  
AND ANTICIPATE THE RAPID GROWTH OF ELDERS IN THE COMMUNITY



### Purpose of Events or Activities

The purpose(s) of holding an event or activity are shown in Table 11 and Figure 17 for the eight OAA target groups, to address the rapidly growing senior population, and for other local initiatives. Figure 17 shows that regardless of the target group, COAs held events or activities to conduct general outreach (67%-85%) and provide information and referral services (58%-83%).

COAs also undertook outreach for emergency support when addressing the abused, neglected, exploited and self-neglected elders (58%), frail elders (52%), and elders in rural communities (46%). Physical/environmental improvement events were most often held when addressing frail elders and elders with physical and mental disabilities. Volunteer development activities were primarily conducted when addressing elder isolation, elders with limited English proficiency, and the rapidly growing senior population. Least offered were intergenerational events and activities, but when held were often directed to elders with limited English proficiency.

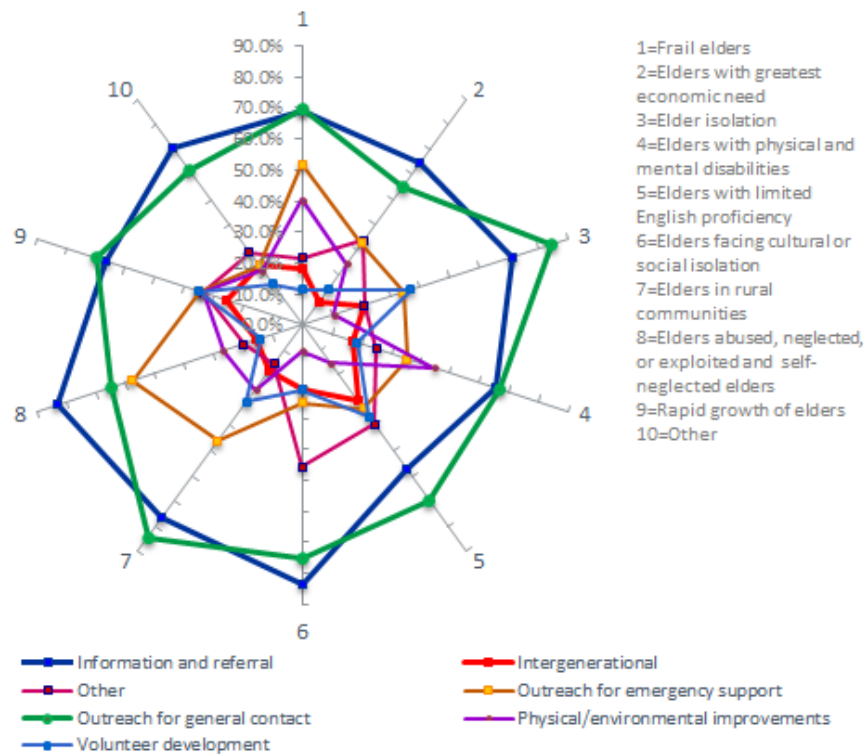
Table 11  
EVENT OR ACTIVITY HELD TO ADDRESS A SPECIFIC TARGET GROUP  
AND TO ADDRESS THE RAPID GROWTH OF ELDERS

Purpose	Frail elders		Greatest economic need		Elder isolation -- identifiable racial or ethnic groups		Physical and mental disabilities		Limited English Proficiency		Cultural or social isolation		Elders in rural communities		Abused, neglect or exploited & self-neglected elders		Rapid growth of elders		Other	
	106		98		38		76		33		24		39		71		86		55	
	T	%	T	%	T	%	T	%	T	%	T	%	T	%	T	%	T	%	T	%
Information and referral	73	68.9%	63	64.3%	27	71.1%	50	65.8%	19	57.6%	20	83.3%	30	76.9%	59	83.1%	57	66.3%	39	70.9%
Intergenerational	19	17.9%	9	9.2%	8	21.1%	13	17.1%	10	30.3%	5	20.8%	7	17.9%	11	15.5%	22	25.6%	13	23.6%
Outreach for emergency support	55	51.9%	32	32.7%	13	34.2%	27	35.5%	11	33.3%	6	25.0%	18	46.2%	41	57.7%	30	34.9%	13	23.6%
Outreach for general contact	74	69.8%	54	55.1%	32	84.2%	51	67.1%	23	69.7%	18	75.0%	33	84.6%	46	64.8%	60	69.8%	34	61.8%
Physical/environmental improvement	43	40.6%	24	24.5%	4	10.5%	34	44.7%	5	15.2%	2	8.3%	10	25.6%	19	26.8%	29	33.7%	12	21.8%
Volunteer development	12	11.3%	14	14.3%	14	36.8%	14	18.4%	12	36.4%	5	20.8%	12	30.8%	10	14.1%	30	34.9%	9	16.4%
Other	23	21.7%	33	33.7%	8	21.1%	19	25.0%	13	39.4%	11	45.8%	6	15.4%	14	19.7%	29	33.7%	16	29.1%



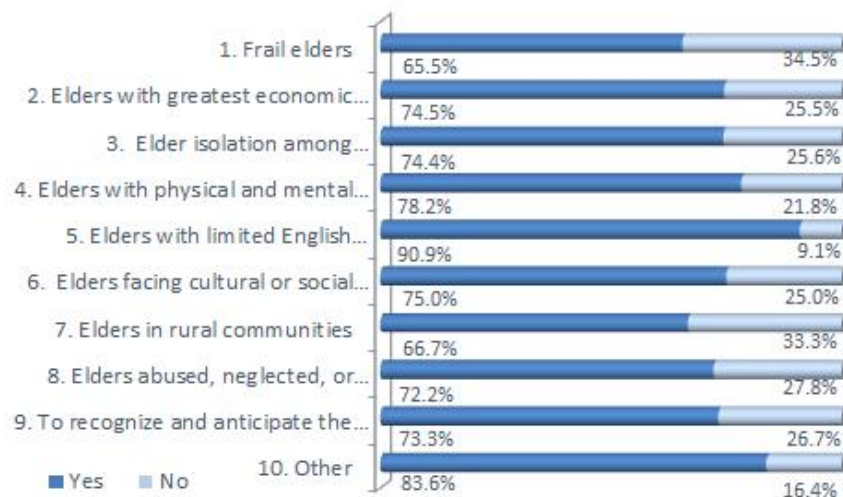


Figure 17  
EVENT OR ACTIVITY HELD TO ADDRESS A SPECIFIC TARGET GROUP  
AND TO ADDRESS THE RAPID GROWTH OF ELDERS



The majority of respondents who reported an event or activity for an initiative are also willing to share it with their colleagues (Figure 18). Willingness to share their events or activities with other communities range from 66% for Frail elders to 91% for Limited English proficiency. Across 644 events and activities conducted by COAs, 74% (477) will be reported in a separate document.

Figure 18  
SHARE INITIATIVE WITH OTHERS





## SUMMARY AND CONCLUSION

COAs are providing essential services for elders. The scope and depth of services vary across COAs but all are providing specific services elders use and depend upon to remain engaged in their communities. The current service priorities of COAs are transportation, physical activity and wellness, community outreach, leisure and recreational activities, and nutrition services.

With regard to transportation options for elders, COAs served an estimated 153,000 elders in SFY 2012. Transportation services were most often provided for a medical appointment, to secure or purchase food, and to attend a function at the senior center. Transportation will continue to be a service priority for COAs currently providing transportation options and is projected to become somewhat more important during the next 3-5 years.

COAs provide a wide range of health and disease prevention activities and services. COAs offered the three evidence-based programs promoted by ACL, but more than a third of COAs also cite other activities that promote regular physical activity and to help reduce risk of disease, disability and injury to oneself. More than 90% of the COAs sponsor physical activity programs; more than a third also report having fitness equipment at their senior centers. COAs hold a broader definition of evidenced-based programs that promote healthy aging and wellness (e.g., endurance, balance, muscular strengthening, flexibility and stretching activities). With almost all COAs currently rendering services to reduce risk of disease, disability and injury to oneself, these services are also reported to become somewhat more important during the next 3-5 years.

Less than half of the COAs held an activity to recognize and anticipate the rapid growth of elders in their respective community as well as to address better planning to reflect residents' vision of their respective "livable" community. Those that have addressed the growth of the elder population in their communities, in contrast to those that have not, project that the rapid growth of elders will become somewhat more important during the next 3-5 years. As ACL and long-term care support and policies are directing elder services away from institutional to community based services, COAs will continue to have a role in planning for a "livable" community for elders who favor the community setting as the long-term care option of choice.

COAs serve a key role in emergency management planning for people who require additional assistance during natural or man-made emergencies. About two-thirds of the communities maintain a registry of people who require additional assistance to respond to emergencies. On the other hand, 25% of COAs are unsure if a registry is maintained in their respective community. In nearly half of the communities that maintain a registry, the COA is identified as the department responsible to maintain and update the registry. Improving emergency response capacity for homebound and adult disabled residents is cited by COAs as an area that will be somewhat more important in the next 3-5 years.

Housing was not a current top five service priority area; however, more than two-thirds of COAs are helping with home costs such as property taxes, fees, water/sewer, home utility and cable/internet/phone bills, and more than half are addressing home modification, repair and maintenance services. Less than half are focusing on increasing affordable housing capacity. From among all initiative's currently being addressed by COAs though, increasing affordable housing capacity is at the forefront of importance and is considered to become much more important during the next 3-5 years, even ahead of transportation options for elders.

The vast majority of COAs promote social connections and volunteer/civic engagement activities; however, only about a fifth listed this service area in the current top five priority areas. COAs that conduct social connections and volunteer/civic engagement activities also project that this service area will be somewhat more importance during the next 3-5 years. While continuing to be offered by COAs, its importance level, however, will likely be overshadowed by attention on increasing public and paratransit options, increasing affordable housing capacity, improving emergency response capacity, promoting healthy aging and wellness, and promoting leisure and recreational activities. Communities currently engaged in physical planning to enhance elder mobility and improving access to mental health services also project that these service areas will be somewhat more important during the next 3-5 years. These service areas are likely be addressed ahead of promoting pedestrian and driver safety and employment retention or workforce development in the next 3-5 years.



Finally, community outreach, a current COA priority, is predominately undertaken by conducting general outreach and providing information and referral services. Community outreach is rendered to all OAA target groups, although not uniformly across target groups. More than half of the COAs have undertaken community outreach for frail elders as well as communities with large numbers of identifiable isolated racial/ethnic groups of elders, LEP elders, and elders residing in rural communities. Less than half of the COAs reported outreach to elders with greatest economic need. About a third of COAs reported outreach to elders with physical and mental disabilities including mobility limitations, and for abused, neglected or exploited and self-neglected elders. The least number of reported community outreach has been directed to elders facing cultural or social isolation including LGBTs.



## 2013 NEEDS ASSESSMENT SURVEY MUNICIPAL QUESTIONNAIRE

### Appendix A

In preparation for the 2014-2017 State Plan on Aging, the Executive Office of Elder Affairs asks for your assistance to help us become better informed of the services being offered and each COA's preparedness to address the rapidly growing senior population.

Please assist us by completing this three-part questionnaire.

Part A seeks information about your current service priorities and initiatives the COA will focus on during the next 3-5 years.

Part B requests program information regarding transportation, emergency management planning, evidence-based programs pertaining to injury/fall prevention, and physical activities.

Part C seeks information on the types of initiatives the COA has undertaken to address specific target groups identified in the Older Americans Act of 1965 and to prepare for the rapidly growing elder residents in your community.

You do not need to complete the survey all at once. As long as you use the same computer, you will be able to return to the questionnaire, as well as change your responses, until the closing date Wednesday, November 21, 2012. Results will be reported in the aggregate.

Thank you in advance for your consideration and partnership in this effort.

#### Survey Respondent

Name and title of COA responder (director or COA board chair)

Name:

Position title:

**Do you receive municipal funding from OTHER towns to support your senior center(s)?**

Yes - GO TO

**Please list the towns/communities. (Open ended)**

No - GO TO

**Please select your city or town. (351 municipalities listed)**

**My Area Agency on Aging is:** (Select from a drop down list)

**What percent of your unduplicated counts of seniors reside in another community?**

Less than 5%

5% - 9%

10%-14%

15%-19%

20%-24%

25%-29%

30%-34%

35% or more

#### Part A. Service Priorities for Elders

1. Current Service Priorities - Eighteen service areas for elders are listed alphabetically. Please indicate the top FIVE areas your community is currently providing to support elders. If a priority area is not listed, please add under "Other."

Community outreach

Education and arts programs

Family/caregiving/support groups

Financial/economic security including tax work off

Health care

Health insurance and benefits

Housing

Legal assistance

Leisure and recreational activities

Long-term care in the community (e.g., home care services)

Mental and behavioral health

Nutrition

Physical activity and wellness



Safety and security (public and personal)  
 Spirituality  
 Transportation  
 Volunteer/civic engagement  
 Workforce development  
 Other (write in

## 2. Service Delivery Focus in the next 3-5 years

Fourteen initiatives are listed. (Seven are listed below and seven in the next screen.) For each initiative, indicate (Yes/No) if the initiative is currently being addressed by the COA. Secondly, rate how important each initiative will likely be for the COA during the next three to five years.

**Scale:** Currently being addressed - Yes, No

Level of importance: Much less important

Somewhat less important

Same importance/No change

Somewhat more important

Much more important

### Answer options:

	Being Addressed	How important
1. Assist elders with home modification, repair and maintenance services.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
2. Better planning to reflect residents' vision of "livable" community.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
3. Encourage employment retention, training/retraining and recruitment of older workers.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
4. Increase affordable elder housing capacity.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
5. Engage in physical planning to enhance elder mobility.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
6. Help with home costs such as property taxes/fees, water/sewer, home utility, and cable/internet/phone bills	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
7. Improve access to mental health services along with screening, education and support programs.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
8. Improve our emergency response capacity for homebound and adult disabled residents.	Yes No	Much less important Somewhat less important Same importance/No change



		Somewhat more important Much more important
9. Promote healthy aging and wellness (physical activity/fitness/falls prevention).	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
10. Promote elder leisure and recreational activities.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
11. Promote pedestrian and driver safety in community design and planning.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
12. Promote preventative health care, screenings and immunizations.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
13. Promote public and paratransit transportation options.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important
14. Promote social connections and volunteer/civic engagement in the community.	Yes No	Much less important Somewhat less important Same importance/No change Somewhat more important Much more important

## Part B. Transportation, Emergency Management Planning, Evidenced-Based Programs, and Physical Activities

### Transportation

1. Does your Senior Center use paratransit or other service (e.g., vans, mini buses, private cars) to transport persons with mobility limitations?

**Yes** - Answer 1.a & 1.b

1.a Does the paratransit vehicle transport elders including persons with mobility limitations to the following places or activity? (Check all that apply.)

**Answer options:**

- the senior center
- a congregate meal site
- an employment center or place of employment
- a food/grocery store
- a mall or shopping center
- a medical appointment
- a polling site
- a social or recreational activity
- other (please specify)\_\_\_\_\_

1.b Please complete the following:

**Answer options:**

- 1) How many vans, buses, minibuses are used by your senior centers to transport elders? \_\_\_\_\_
- 2) How many elders (unduplicated count) were transported in state fiscal year 2012 (7/1/11-6/30/12)? \_\_\_\_\_
- 3) How many total hours a week are vehicles on the road? (An average or best estimate is acceptable.) \_\_\_\_\_

**No** - GO TO Emergency Management Planning

### Emergency Management Planning

2. Should a natural or man-made disaster/threat occur in your community, does your municipality maintain a registry or record of people who require additional assistance to respond to emergencies?



**Yes -- GO TO 2.a, 2.b, & 2.c**

**No - GO TO Evidenced-based prevention program**

**Unsure - GO TO Evidenced-based prevention program**

2.a Please tell us the name of the department(s) that is/are responsible for maintaining and updating the registry information? (Check all that apply.)

**Answer options:**

911 Center/Dispatch (may be under Fire, Police or EMS)

Aging Services Access Points (ASAP)

Area Agency on Aging (AAA)

Board of Health

Council on Aging

Emergency Management (includes Civil Defense and Emergency Response or Preparedness Team)

Fire Department

Police Department

Senior Center

Sheriff's Department

TRIAD

Other

2.b As of July 2012, how many people who require additional assistance (e.g., homebound people, elders and adults with disabilities) are currently "registered" with your community? (Pick one)

**Answer options:**

Less than 25

25 to 49

50 to 74

75 to 99

100 to 149

150 to 199

200 to 299

300 or more

Unknown or not sure

Other

2.c Do you meet regularly with other municipal departments?

**Yes GO TO**

**No GO TO Evidenced-based prevention program**

2.c.1 How often does the Council meet with each of the following departments? (Mark one response for each department.) **Scale:** Monthly - Every other month - Quarterly - Biannually - Annually - Not applicable

Departments	Monthly	Every other month	Quarterly	Biannually	Annually	Not applicable
EMS						
Fire						
Housing						
Human Services						
Police						
Public Health						
Parks & Recreation						
Veterans						

**Evidenced-based Prevention Programs**

As defined by the Administration for Community Living (formerly Administration on Aging), "evidenced based prevention programs are interventions...that have been proven effective in reducing the risk of disease, disability, and injury among elder."

3.a For each of the following evidence-based program, please indicate if you have offered/sponsored the program in your community AND the number of times the entire program was offered in the past 12 months.

For example, A Matter of Balance compose of six sessions was offered in January 2012 and again in July 2012. Your responses for A Matter of Balance are "Yes" under Program Offered, and "2" under Number of times. If a program is not offered, indicated "Not applicable" under Number of times.

**Scale:** Program Offered (Yes/No) - Number of times

**Answer options:**

Program Offered # of times

Chronic Disease Self-Management Program

Yes/No

\_\_\_\_\_





Healthy Eating for Successful Living in Older Adults	Yes/No	_____
A Matter of Balance	Yes/No	_____

2. Please list other evidenced-based fall prevention program(s) AND the number of times each was offered in your community in the past 12 months.

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#### Strength, Flexibility and Cardiovascular Activities

According to the Centers of Disease Control and Prevention (CDC), regular physical activity is participation in three or more 20-minute sessions per week that makes the person sweat or five or more 30 minute sessions of slower activity such as walking.

4. Does your senior center(s) sponsor or offer physical activity programs?

Yes - GO TO 4.a

No - GO TO Part C

4.a Reviewing your records for the past 12-18 months, please list the FIVE most popular (highest number of participants) types of strength, flexibility and cardiovascular activities.

Some examples of physical activities you may have offered are:

Aerobics  
Bicycling  
Bowling  
Dancing  
Pilates  
Qigong  
Tai chi  
Stretching  
Volleyball  
Walking  
Water exercises/swimming  
Weight training  
Wii fitness  
Yoga

**Answer options:**

Most popular physical activity \_\_\_\_\_  
2nd most popular physical activity \_\_\_\_\_  
3rd most popular physical activity \_\_\_\_\_  
4th most popular physical activity \_\_\_\_\_  
5th most popular physical activity \_\_\_\_\_

4.b Do you have fitness equipment at your center?

Yes - GO TO 4.c

No - GO TO Part C

4.c Other than hand weights, please list in descending order, the fitness equipment most in use. For example: back extension machine, elliptical machine, free weights, resistance bands, treadmill, and upright or recumbent bicycle.

**Answer options:**

Fitness equipment most in use \_\_\_\_\_  
Fitness equipment second most in use \_\_\_\_\_  
Fitness equipment third most in use \_\_\_\_\_  
Fitness equipment fourth most in use \_\_\_\_\_  
Fitness equipment fifth most in use \_\_\_\_\_

#### Part C. Initiatives to Address Specific Target Groups Identified in the Older Americans Act and the Rapidly Growing Senior Population

Please share an initiative (e.g., an activity or event) that the COA or senior center(s) conducted in the past three years for each of the eight target groups identified under the Older Americans Act of 1965 and to recognize and anticipate the rapid growth of elders in your community.



The eight target groups identified under the Older Americans Act of 1965 are:

1. Frail elders
2. Elders with greatest economic need (resulting from an income level at or below the poverty level)
3. Elder isolation among identifiable racial or ethnic groups
4. Elders with physical and mental disabilities including mobility limitations
5. Elders with limited English proficiency
6. Elders facing cultural or social isolation including lesbian, gay, bisexual, and transgender (LGBT) individuals
7. Elders in rural communities
8. Elders abused, neglected, or exploited and self-neglected elders

For each target group, indicate (Yes/No) if an initiative has been conducted. If Yes is indicated, also complete the following under each header.

- A. Initiative name - Self-explanatory.
- B. Initiative purpose(s) -- Indicate one or more purposes.
- C. Brief description -- Provide a brief description of the initiative.
- D. Major outcome(s) -- Report one or more major outcomes from conducting the initiative.
- E. Share initiative with others? Are you willing to share the initiative/information with others? Yes/No

### 1. Frail elders

Did the COA/senior center(s) conduct an initiative in the past three years to address frail elders? (According to the Older Americans Act of 1965, Sec 102 (26), "frail" with respect to older individuals, is determined to be functionally impaired because the individual is unable to perform at least two activities of daily living without substantial human assistance; or requires substantial supervision because the individual behaves in a manner that poses a serious health or safety hazard to the individual or another individual.)

Yes (If Yes, answer A-E)

No (If No, go to #2)

- A. Initiative name \_\_\_\_\_
- B. Primary purpose of the initiative (pick one)  
**Answer options:**  
Information and referral  
Intergenerational  
Outreach for general contact  
Outreach for emergency support  
Physical/environmental improvements  
Volunteer development  
Other (specify) \_\_\_\_\_
- C. Brief description (open ended)
- D. Major outcome(s)
- E. Share initiative with others? Yes    No

### 2. Elders with greatest economic need (resulting from an income level at or below the poverty line)

Did the COA/senior center(s) conduct an initiative in the past three years to address elders with greatest economic need?

Yes (If Yes, answer A-E)

No (If No, go to #3)

- A. Initiative name \_\_\_\_\_
- B. Primary purpose of the initiative (pick one)  
**Answer options:**  
Information and referral  
Intergenerational  
Outreach for general contact  
Outreach for emergency support  
Physical/environmental improvements  
Volunteer development  
Other (specify) \_\_\_\_\_
- C. Brief description (open ended)
- D. Major outcome(s)
- E. Share initiative with others? Yes    No

### 3. Elder isolation among identifiable racial or ethnic groups

Did the COA/senior center(s) conduct an initiative in past three years to address elder isolation among identifiable racial or ethnic groups?

Yes (If Yes, answer A-E)

No (If No, go to #4)

- A. Initiative name \_\_\_\_\_
- B. Primary purpose of the initiative (pick one)



**Answer options:**

Information and referral  
Intergenerational  
Outreach for general contact  
Outreach for emergency support  
Physical/environmental improvements  
Volunteer development  
Other (specify)

- C. Brief description (open ended)  
D. Major outcome(s)  
E. Share initiative with others? Yes No

**4. Elders with physical and mental disabilities including mobility limitations**

Did the COA/senior center(s) conduct an initiative in the past three years to address elders with physical and mental disabilities including mobility limitations?

Yes (If Yes, answer A-E)

No (If No, go to #5)

- A. Initiative name \_\_\_\_\_  
B. Primary purpose of the initiative (pick one)

**Answer options:**

Information and referral  
Intergenerational  
Outreach for general contact  
Outreach for emergency support  
Physical/environmental improvements  
Volunteer development  
Other (specify)

- C. Brief description (open ended)  
D. Major outcome(s)  
E. Share initiative with others? Yes No

**5. Elders with limited English proficiency**

Did the COA/senior center(s) conduct an initiative in the past three years to address elders with limited English proficiency?

Yes (If Yes, answer A-E)

No (If No, go to #6)

- A. Initiative name \_\_\_\_\_  
B. Primary purpose of the initiative (pick one)

**Answer options:**

Information and referral  
Intergenerational  
Outreach for general contact  
Outreach for emergency support  
Physical/environmental improvements  
Volunteer development  
Other (specify)

- C. Brief description (open ended)  
D. Major outcome(s)  
E. Share initiative with others? Yes No

**6. Elders facing cultural or social isolation including lesbian, gay, bisexual, and transgender (LGBT) individuals**

Did the COA /senior center(s) conduct an initiative in the past three years to address elders facing cultural or social isolation including LGBT individuals?

Yes (If Yes, answer A-E)

No (If No, go to #7)

- A. Initiative name \_\_\_\_\_  
B. Primary purpose of the initiative (pick one)

**Answer options:**

Information and referral  
Intergenerational  
Outreach for general contact  
Outreach for emergency support



- Physical/environmental improvements
- Volunteer development
- Other (specify)
- C. Brief description (open ended)
- D. Major outcome(s)
- E. Share initiative with others? Yes No

**7. Elders in rural communities**

Did the COA/senior center(s) conduct an initiative in the past three years to address elders in rural communities?

Yes (If Yes, answer A-E)

No (If No, go to #8)

- A. Initiative name \_\_\_\_\_
- B. Primary purpose of the initiative (pick one)  
**Answer options:**
  - Information and referral
  - Intergenerational
  - Outreach for general contact
  - Outreach for emergency support
  - Physical/environmental improvements
  - Volunteer development
  - Other (specify)
- C. Brief description (open ended)
- D. Major outcome(s)
- E. Share initiative with others? Yes No

**8. Elders abused, neglected, or exploited and self-neglected elders**

Did the COA/senior center(s) conduct an initiative to address elder abuse, neglect, exploitation or self-neglected elders?

Yes (If Yes, answer A-E)

No (If No, go to #9)

- A. Initiative name \_\_\_\_\_
- B. Primary purpose of the initiative (pick one)  
**Answer options:**
  - Information and referral
  - Intergenerational
  - Outreach for general contact
  - Outreach for emergency support
  - Physical/environmental improvements
  - Volunteer development
  - Other (specify)
- C. Brief description (open ended)
- D. Major outcome(s)
- E. Share initiative with others? Yes No

**9. To recognize and anticipate the rapid growth of elders in your community**

Did the COA/senior center(s) conduct an initiative in the past three years to recognize and anticipate the rapid growth of elders in your community?

Yes (If Yes, answer A-E)

No (If No, go to #10)

- A. Initiative name \_\_\_\_\_
- B. Primary purpose of the initiative (pick one)  
**Answer options:**
  - Information and referral
  - Intergenerational
  - Outreach for general contact
  - Outreach for emergency support
  - Physical/environmental improvements
  - Volunteer development
  - Other (specify)
- C. Brief description (open ended)
- D. Major outcome(s)



E. Share initiative with others? Yes No

**10. Other**

Did the COA/senior center(s) conduct an initiative in the past three years to address any “other” area?

Yes (If Yes, answer A-E)

No (If No, go to Comment)

A. Initiative name \_\_\_\_\_

B. Primary purpose of the initiative (pick one)

**Answer options:**

Information and referral

Intergenerational

Outreach for general contact

Outreach for emergency support

Physical/environmental improvements

Volunteer development

Other (specify)

C. Brief description (open ended)

D. Major outcome(s)

E. Share initiative with others? Yes No

Please share any additional information or comments about your COA.



## 2013 Needs Assessment Survey Municipal Questionnaire Appendix B

### SFY 2013 COA RESPONDENTS

Single Funding					Consortia
Abington	Dartmouth	Lee	Oxford	Sutton	Aquinnah
Acushnet	Dedham	Leicester	Palmer	Swampscott	Deerfield
Adams	Douglas	Leominster	Paxton	Swansea	East Brookfield
Agawam	Dracut	Lexington	Peabody	Taunton	Charlemont
Amesbury	Dunstable	Leyden	Pembroke	Tisbury	Chilmark
Arlington	Duxbury	Lincoln	Pepperell	Tolland	Hawley
Ashburnham	East Bridgewater	Longmeadow	Petersham	Topsfield	North Brookfield
Ashland	Eastham	Lowell	Pittsfield	Townsend	Sunderland
Athol	Easthampton	Ludlow	Plainfield	Truro	West Brookfield
Attleboro	Easton	Lynn	Plymouth	Tyngsborough	West Tisbury
Ayer	Edgartown	Lynnfield	Princeton	Upton	Whately
Becket	Everett	Malden	Quincy	Uxbridge	
Belchertown	Fall River	Mansfield	Raynham	Wakefield	
Bellingham	Falmouth	Marblehead	Reading	Wales	
Berkley	Fitchburg	Marion	Rehoboth	Walpole	
Berlin	Florida	Marlborough	Richmond	Waltham	
Beverly	Framingham	Marshfield	Rockport	Warren	
Billerica	Franklin	Mashpee	Rowley	Watertown	
Blackstone	Georgetown	Maynard	Russell	Wellesley	
Blandford	Gloucester	Medfield	Rutland	Wellfleet	
Bolton	Goshen	Medford	Salem	West Newbury	
Boston	Gosnold	Medway	Salisbury	West Springfield	
Boxborough	Granby	Merrimac	Sandisfield	Westborough	
Boxford	Granville	Methuen	Sandwich	Westfield	
Braintree	Greenfield	Middleborough	Scituate	Westford	
Brewster	Groton	Middlefield	Seekonk	Westminster	
Bridgewater	Groveland	Millbury	Sharon	Weston	
Brockton	Hadley	Millis	Sheffield	Westport	
Brookfield*	Halifax	Milton	Sherborn	Westwood	
Burlington	Hampden	Monson	Shirley	Weymouth	
Cambridge	Hanson	Montgomery	Shrewsbury	Wilbraham	
Canton	Harwich	Needham	Somerset	Williamsburg	
Carlisle	Hatfield	New Bedford	Somerville	Williamstown	
Carver	Haverhill	Newbury	South Hadley	Winchendon	
Charlton	Hingham	Newton	Southborough	Winchester	
Chatham	Hinsdale	Norfolk	Southbridge	Windsor	
Chelsea	Holliston	North Andover	Southwick	Winthrop	
Cheshire	Hopkinton	North Attleboro	Spencer	Woburn	
Chester	Hudson	Northborough	Springfield	Worcester	
Colrain	Hull	Norwell	Sterling	Worthington	
Concord	Huntington	Norwood	Stockbridge	Wrentham	
Conway	Ipswich	Oakham	Stoneham		
Cummington	Kingston	Orange	Sturbridge		
Danvers	Lawrence	Orleans	Sudbury		

\*Also funds two consortia.



## **Attachment J – Massachusetts Aging Network**

The OAA establishes a system whereby authorized program funds flow through the SUA to AAAs where they are used to support home and community based supportive and nutrition services. In Massachusetts, there are twenty-three AAAs representing a like number of PSAs. PSAs are collections of communities that any given AAA serves; PSAs in Massachusetts range in size and composition from a single to city (i.e., Boston) to ones that serve over thirty cities and towns.

Responsibilities for overseeing OAA the AAA reside with an Area Planner. AAA Planners solicit and contract with private vendors for services, administer the disbursement of funding, monitor programs for regulatory compliance and maintenance of quality, and generally coordinate operation of services and resources.

AAA and the Planners represent the original structure and system for delivering federally funded services to the elders of the nation and the Commonwealth. In Massachusetts, AAAs provide services in concert with another group of entities known as Aging Services Access Points, (or ‘ASAPs’, authorized within Section 19A of Massachusetts General Laws), which are often colocated with AAAs. ASAPs were formerly known as “Home Care Corporations”, a name that spoke to their principal responsibility of operating the state-funded Home Care Program, a collection of supportive services designed to help elders remain independent and in their own homes, services that naturally complement those of the AAAs. In Massachusetts, there are 27 Aging Services Access Points, 20 of which are colocated with an AAA; seven ASAPs are ‘stand-alone’ entities, leaving three free-standing AAAs that fall outside the ASAP system.

The Massachusetts Elder Service Network includes thousands of dedicated volunteers and many public and private organizations throughout the state. Additional public and private non-profit entities contract with Elder Affairs to locally administer other service programs, including the LTC Ombudsman program and the health benefits counseling program, “Serving the Health Information Needs of Elders” (SHINE). The network includes 349 municipal COAs, 290 senior (and drop-in) centers affiliated with COAs, and 25 independent nonprofit facilities (including 18 in Boston, Springfield and Worcester).

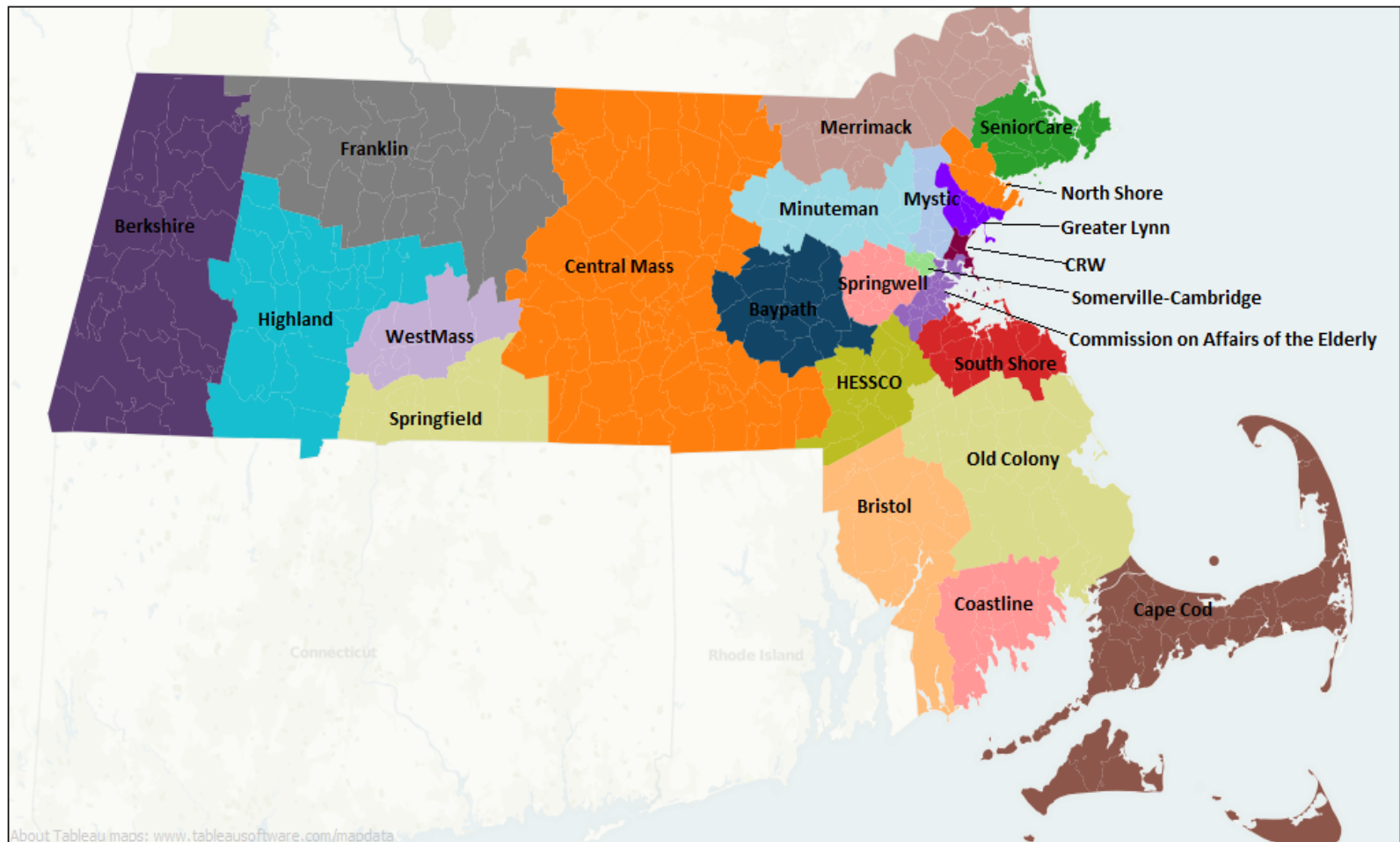
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On the pages that follow is a full map of the Commonwealth with all 23 AAAs represented, along with individual maps of the Commonwealth’s PSAs along with their parent AAA and, in most instances, a colocated ASAP. Towns and cities served are named, their physical arrangement among one another shown and, finally, placed within the context of their location in the Commonwealth. Contact information and addresses are also included. Taken together, the maps represent graphic depiction of the elements that comprise the Elder Service Network in Massachusetts. Lastly, the seven ‘stand-alone’ ASAPs are detailed.





*Commonwealth of Massachusetts*  
*Executive Office of Elder Affairs*  
*Area Agencies on Aging*

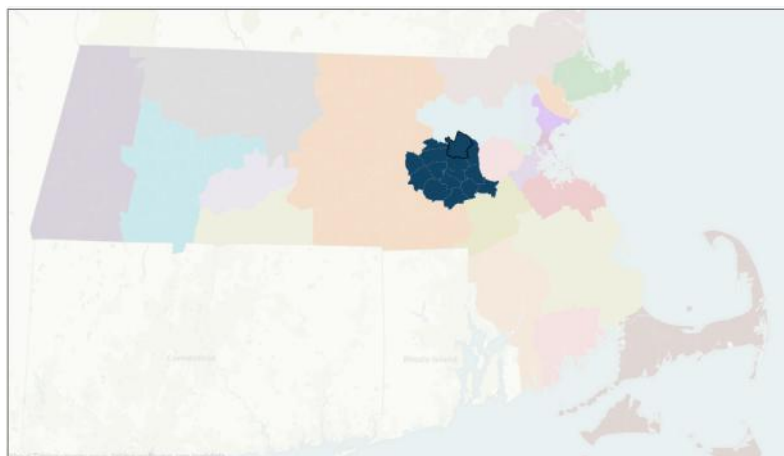
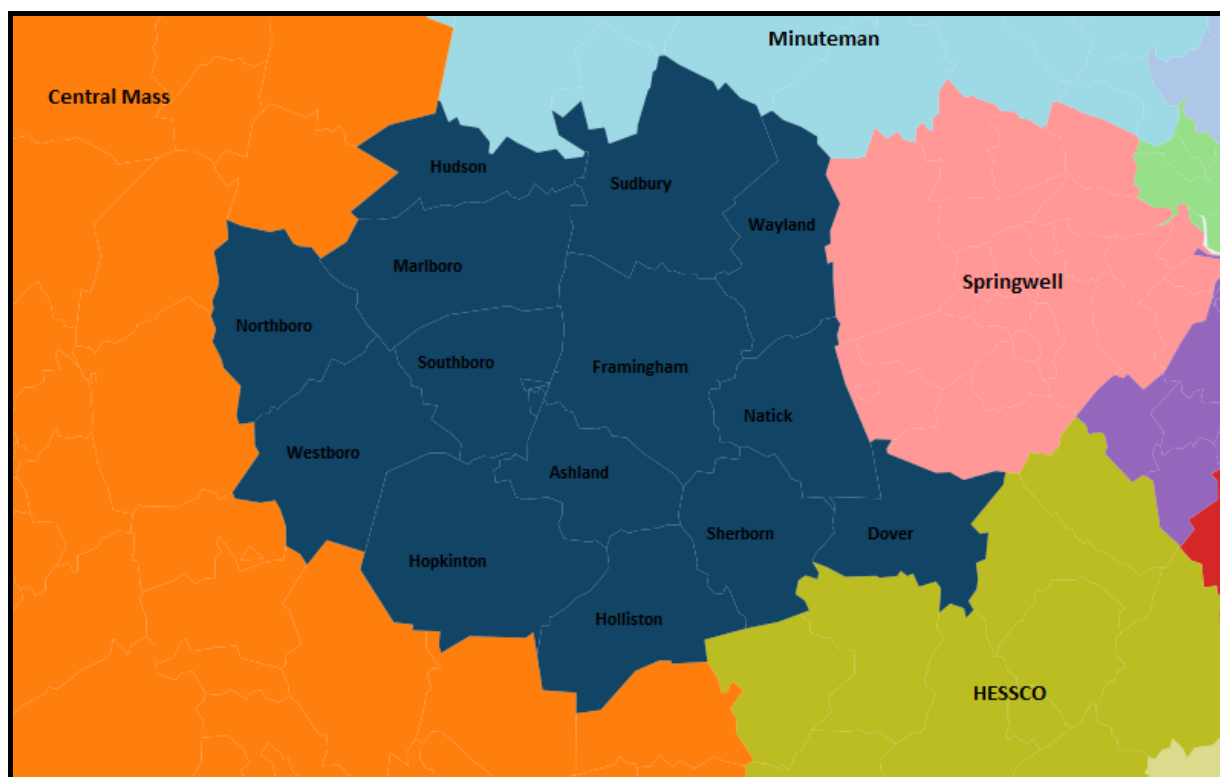




**Baypath Elder Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.baypath.org](http://www.baypath.org)

**33 Boston Post Road West  
Marlborough, MA 01752**

**508-573-7200  
FAX: 508-573-7200  
TTY: 508-573-7282**

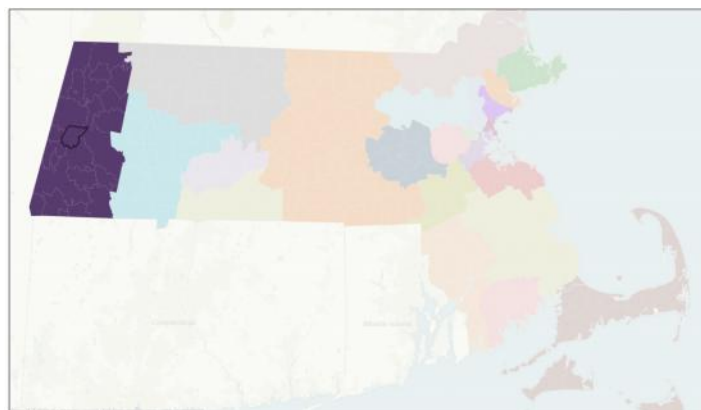
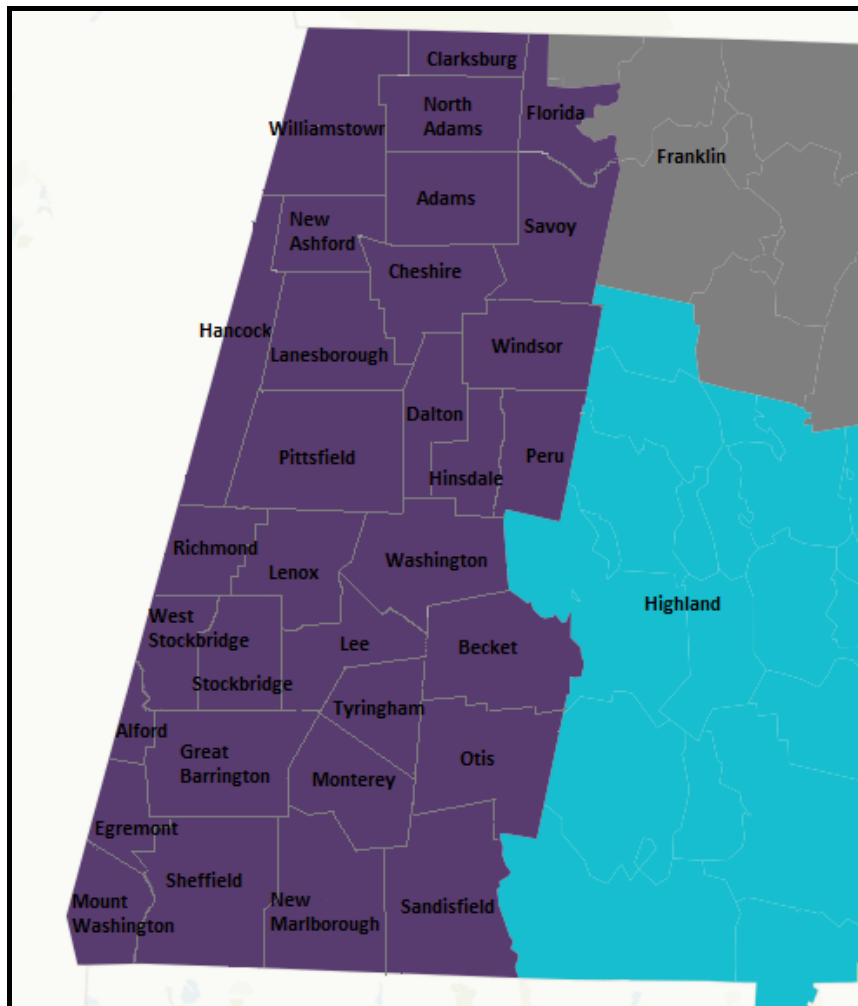




**Elder Services of Berkshire County, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.esbci.org](http://www.esbci.org)

**66 Wendell Avenue  
Pittsfield, MA 01201**

**413-499-0524  
FAX: 413-442-6443  
TTY: 413-499-9764**

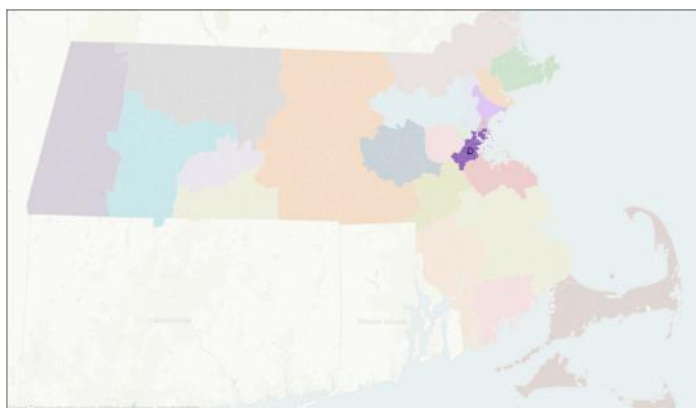
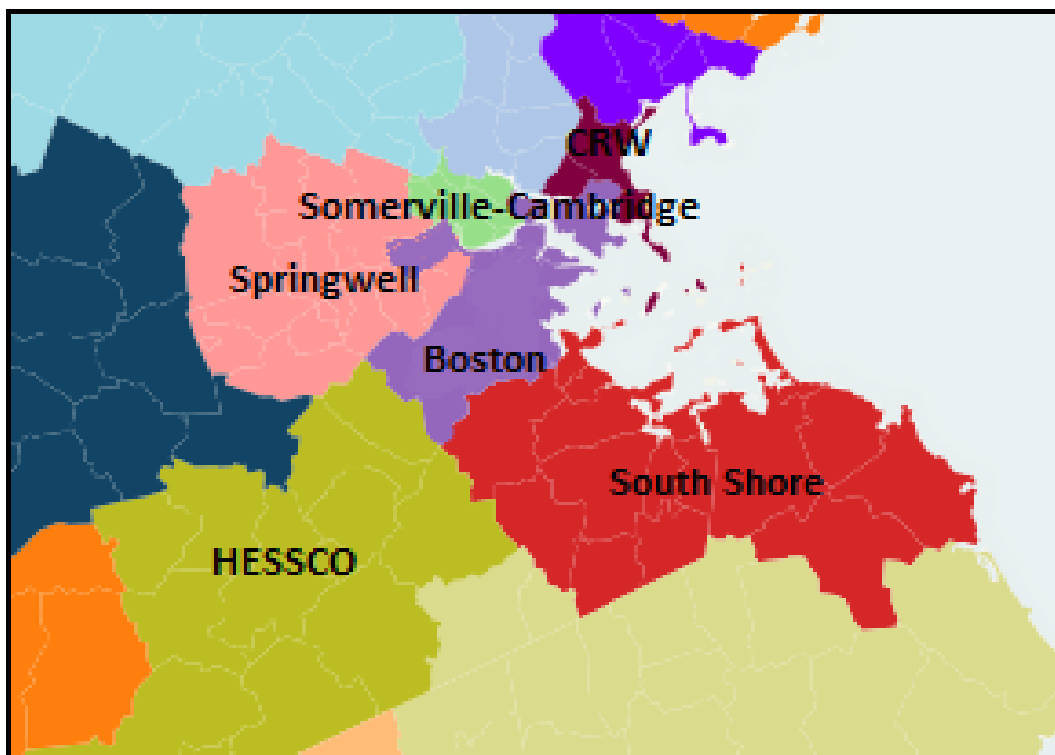




**City of Boston, Commission on Affairs of the Elderly**  
**Area Agency on Aging**  
[www.cityofboston.gov](http://www.cityofboston.gov)

**Boston City Hall**  
**One City Hall Plaza, Room 271**  
**Boston, MA 02201**

**617-635-4366**  
**FAX: 617-635-3213**  
**TTY: 617-635-4599**

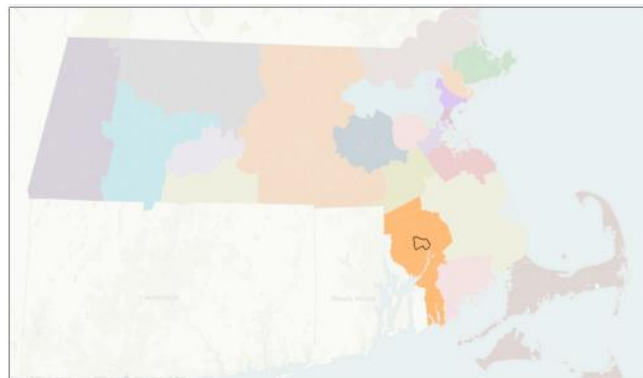
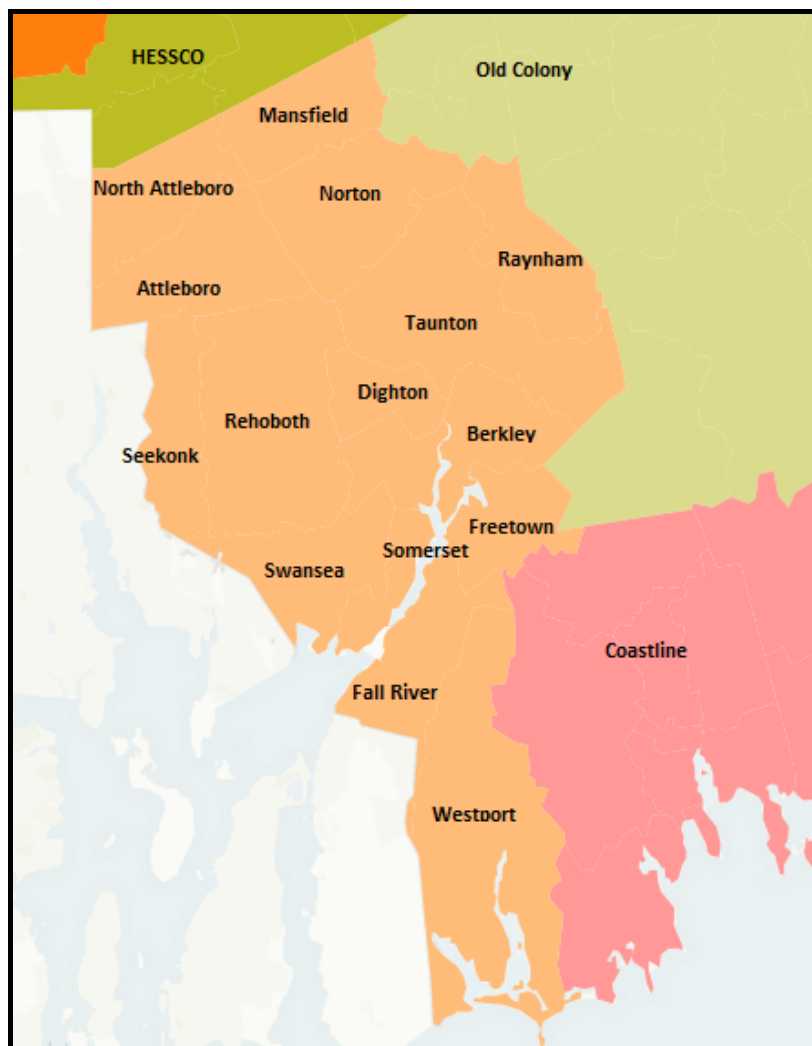




**Bristol Elder Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.bristolelder.org](http://www.bristolelder.org)

**One Father DeValles Blvd, Unit #8**  
**Fall River, MA 02723**

**508-675-2101**  
**FAX: 508-679-0320**  
**TTY: 508-646-9704**

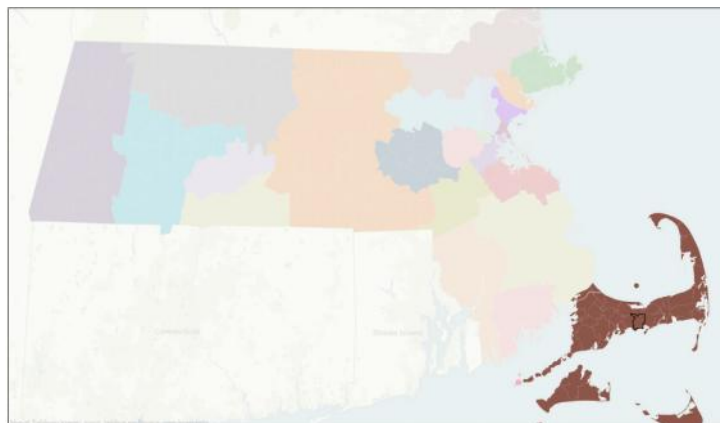
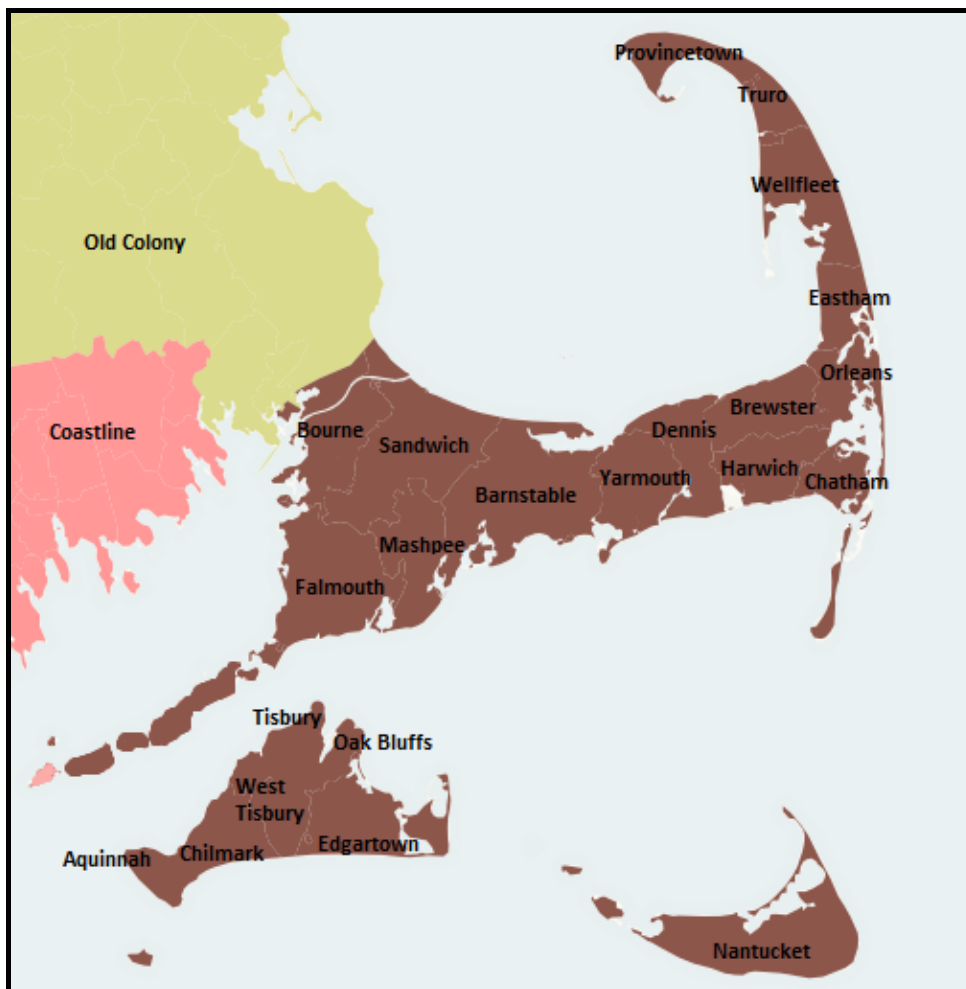




**Elder Services of Cape Cod and the Islands, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.escci.org](http://www.escci.org)

**68 Route 134**  
**South Dennis, MA 02660**

**508-394-4630**  
**FAX: 508-394-3712**  
**TTY: 508-394-8691**

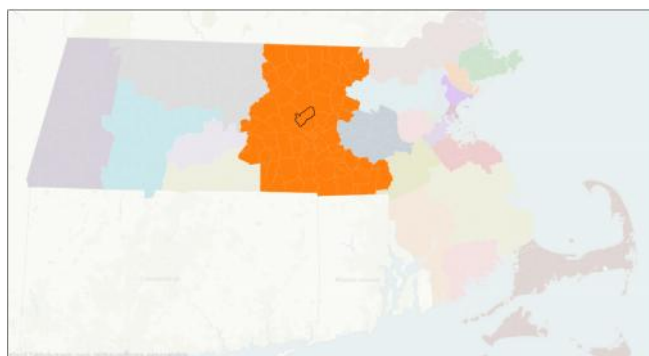




**Central Massachusetts Agency on Aging  
Area Agency on Aging**  
[www.SeniorConnection.org](http://www.SeniorConnection.org)

**360 West Boylston Street  
West Boylston, MA 01583**

**508-852-5539  
FAX: 508-852-5425  
TDD: 508-852-5539**



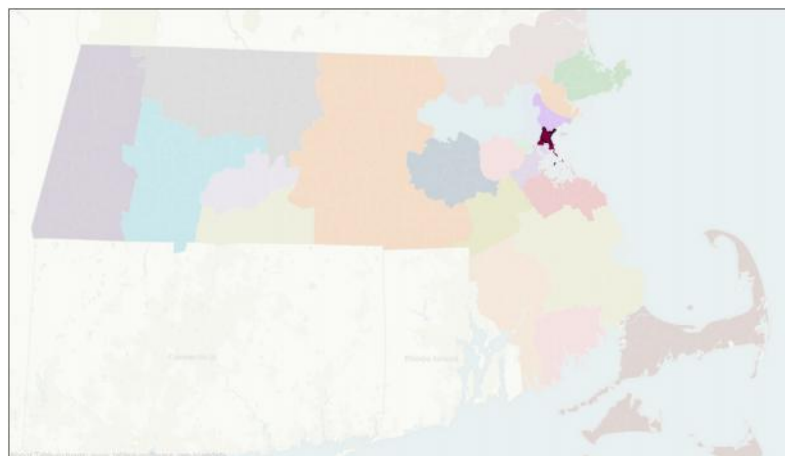
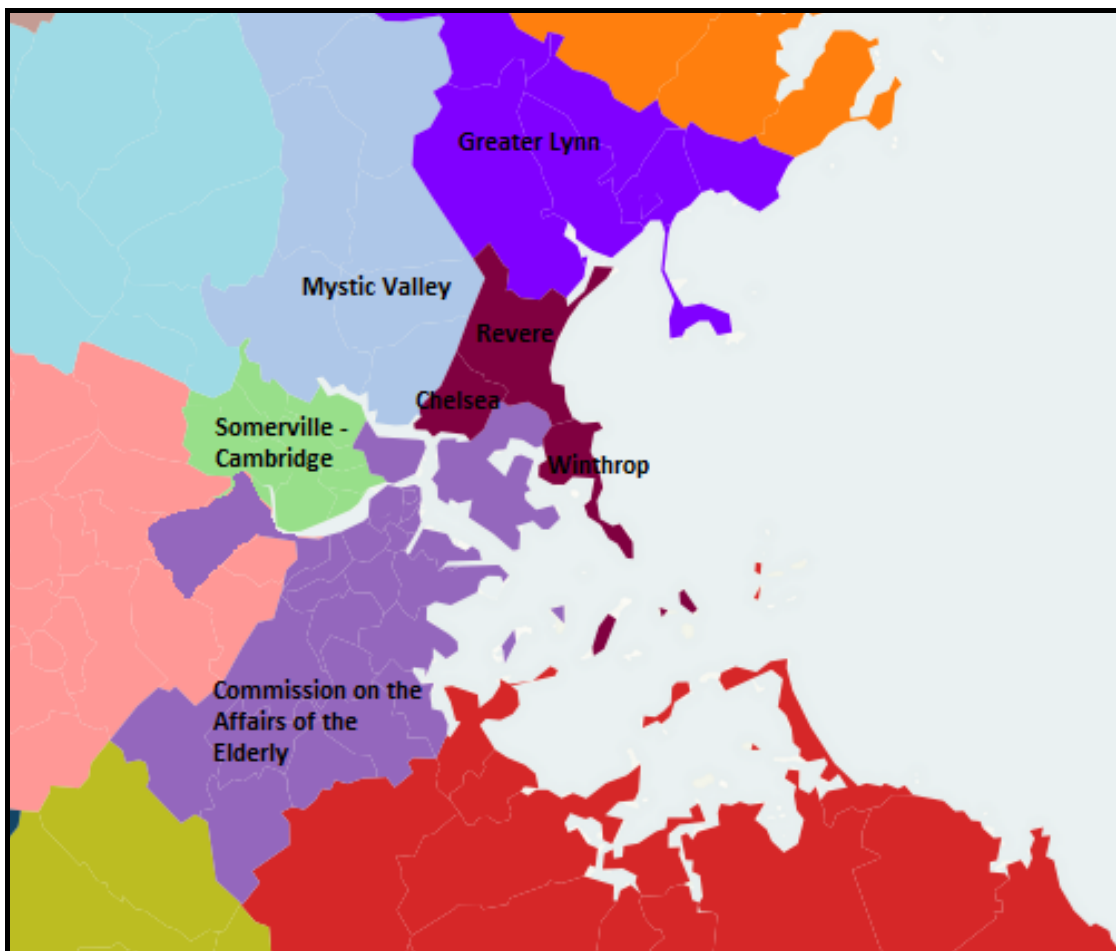




**Chelsea/Revere/Winthrop Elder Services, Inc.**  
**Area Agency on Aging/Aging Services Access Services**  
[www.crwelderservices.org](http://www.crwelderservices.org)

**100 Everett Avenue  
Chelsea, MA 02150**

**671-884-2500  
FAX: 617-884-7988  
TTY: 617-695-0437**

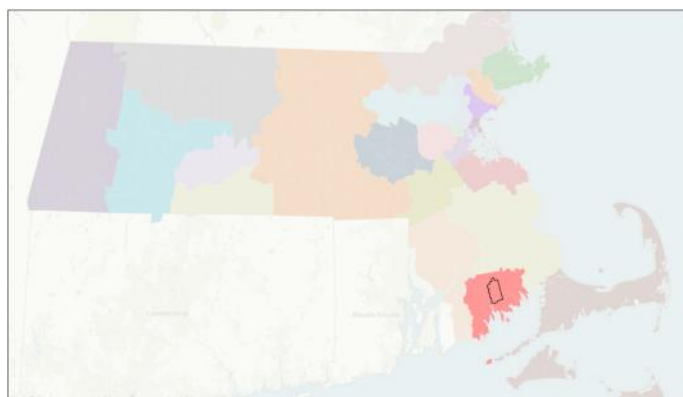
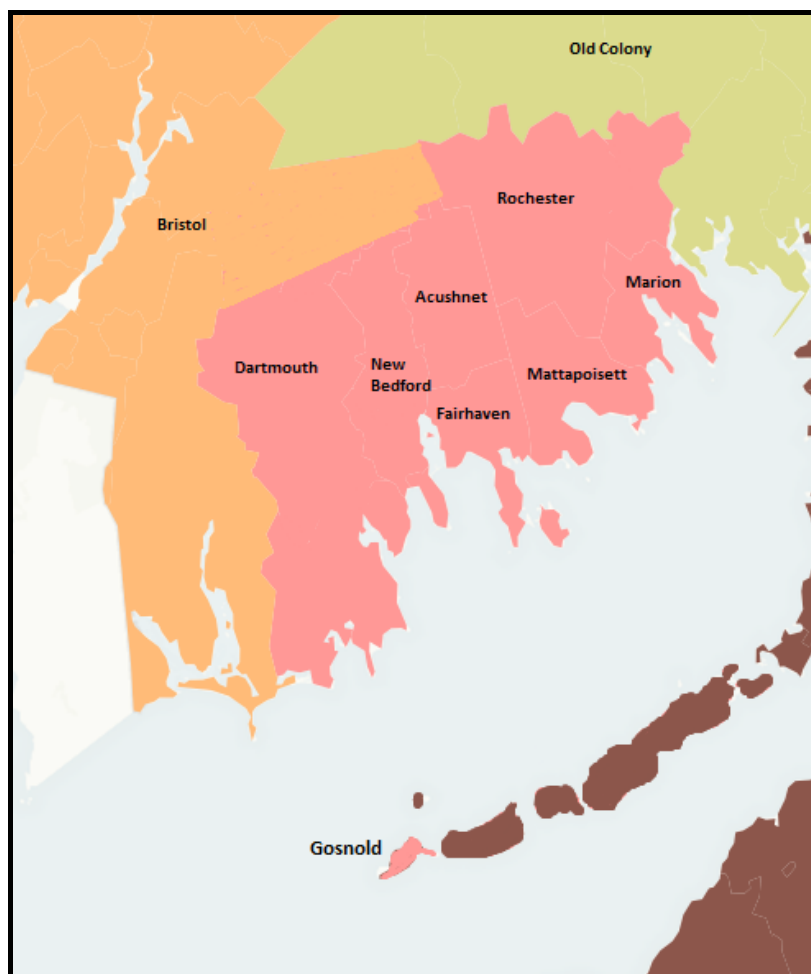




**Coastline Elderly Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.coastlineelderly.org](http://www.coastlineelderly.org)

**1646 Purchase Street**  
**New Bedford, MA 02740**

**508-999-6400**  
**FAX: 508-993-6510**  
**TDD: 508-994-4265**

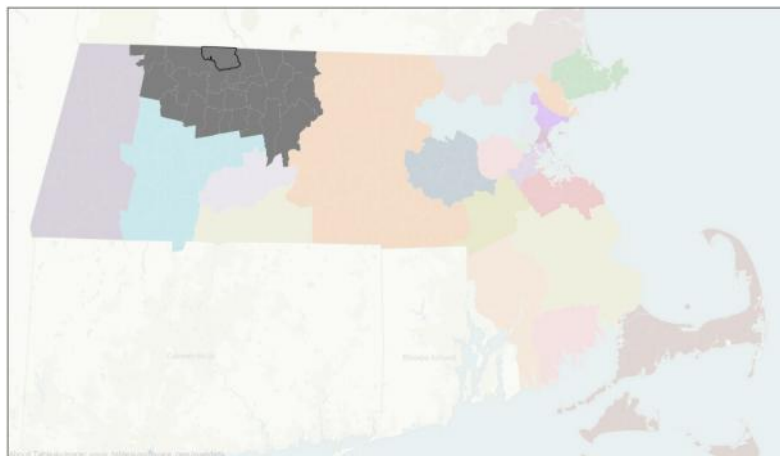
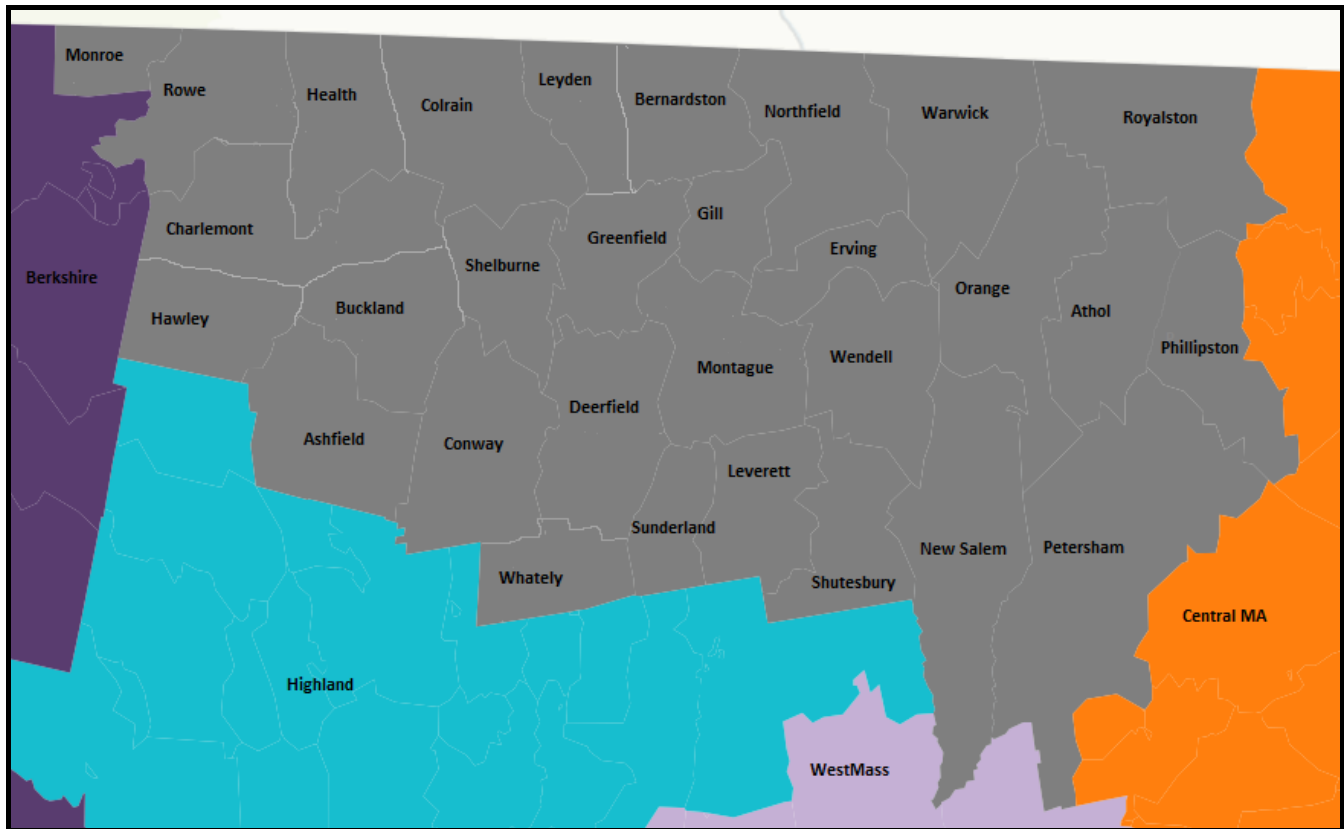




**Franklin County Home Care Corporation**  
**Area Agency on Aging/Aging Services Access Point**  
[www.fchcc.org](http://www.fchcc.org)

**330 Montague City Road, Suite # 1**  
**Turner Falls, MA 01376-2530**

**413-773-5555**  
**FAX: 413-772-1084**  
**TDD: 413-772-6566**

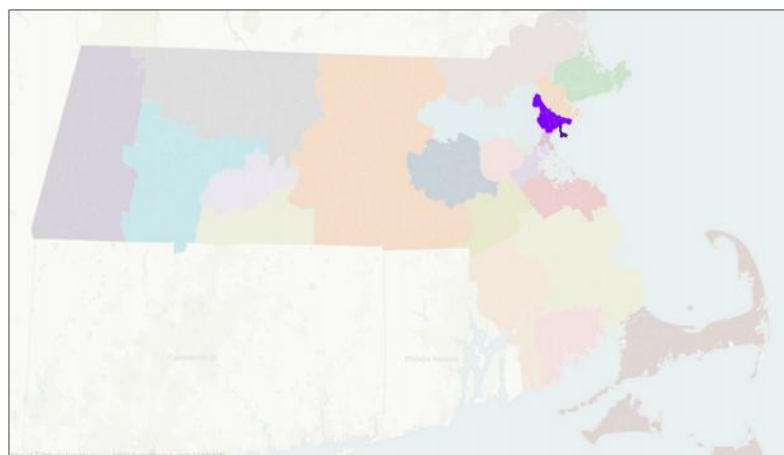
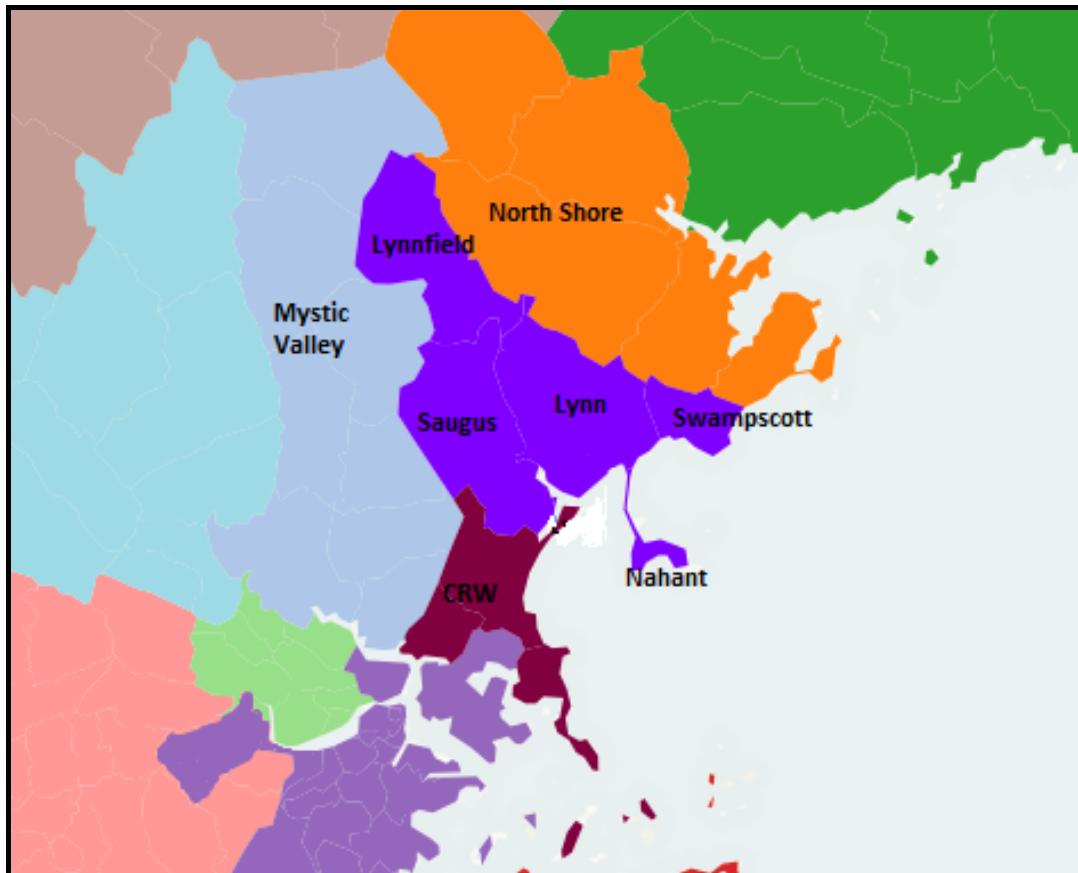




**Greater Lynn Senior Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.glss.net](http://www.glss.net)

**Eight Silsbee Street**  
**Lynn, MA 01901**

**781-599-0110**  
**FAX: 781-592-7540**  
**TDD: 781-477-9632**



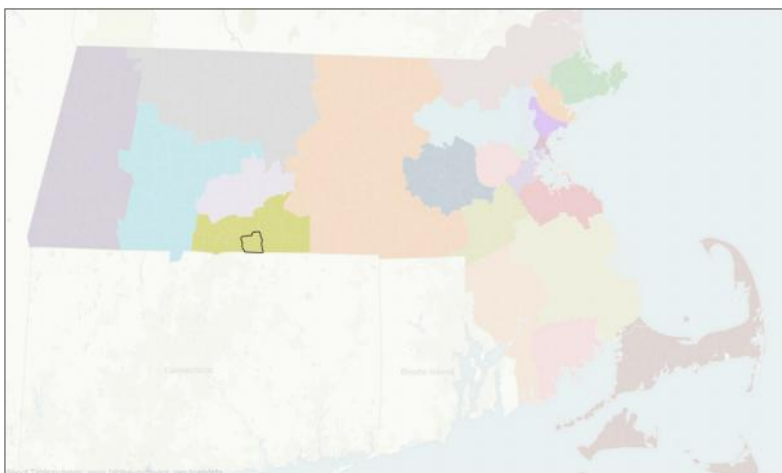
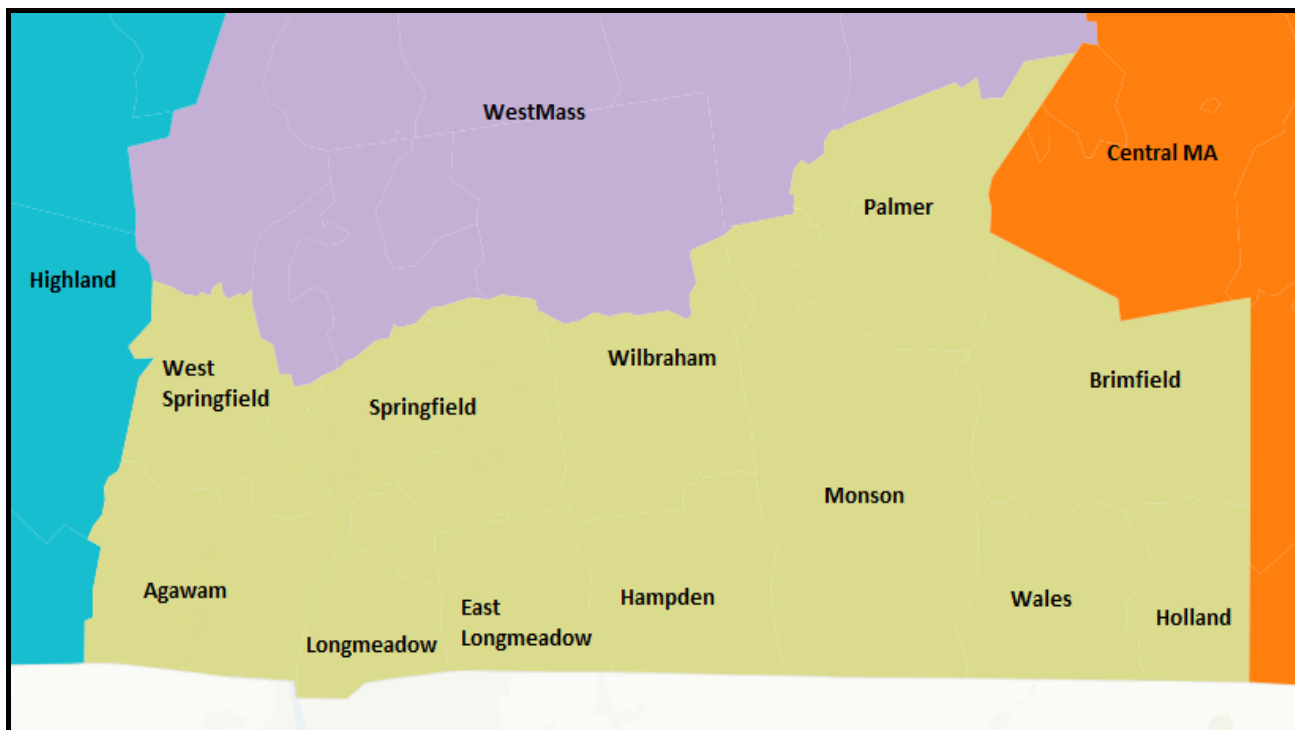


**Greater Springfield Senior Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**

[www.gsssi.org](http://www.gsssi.org)

**66 Industry Avenue, Suite #9**  
**Springfield, MA 01104**

**413-781-8800**  
**FAX: 413-781-0632**  
**TDD: 413-272-0399**

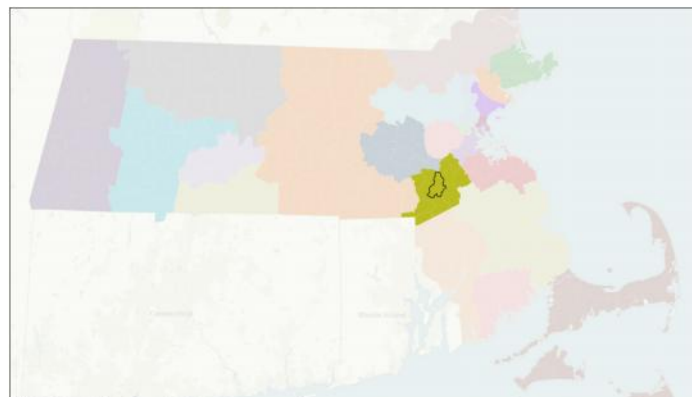
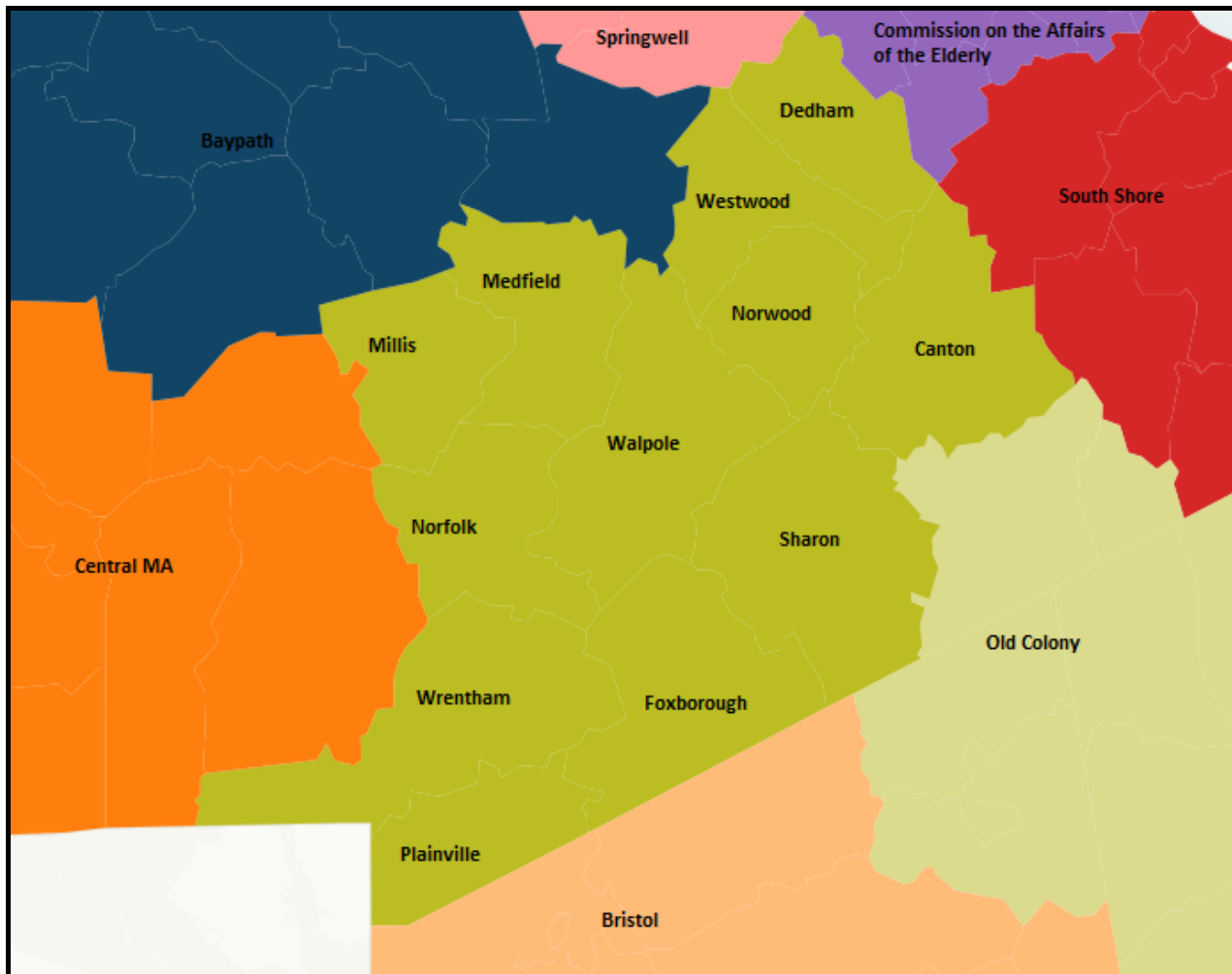




**Health and Social Services Consortium, Inc. (HESSCO)**  
**Area Agency on Aging/Aging Services Access Point**  
[www.hessco.org](http://www.hessco.org)

**One Merchant Street  
Sharon, MA 02067**

**781-784-4944  
FAX: 781-784-4922  
TTY: 800-462-5221**

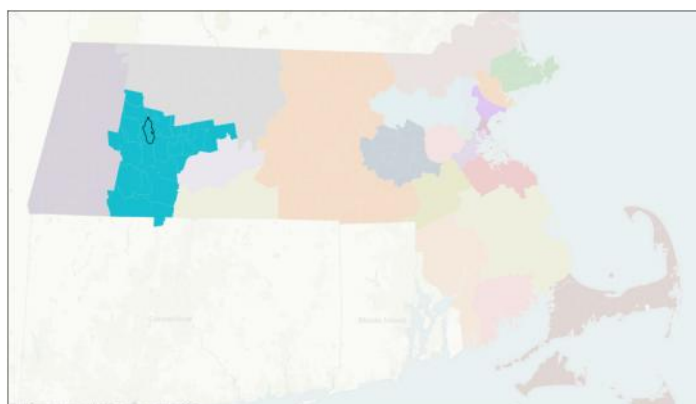
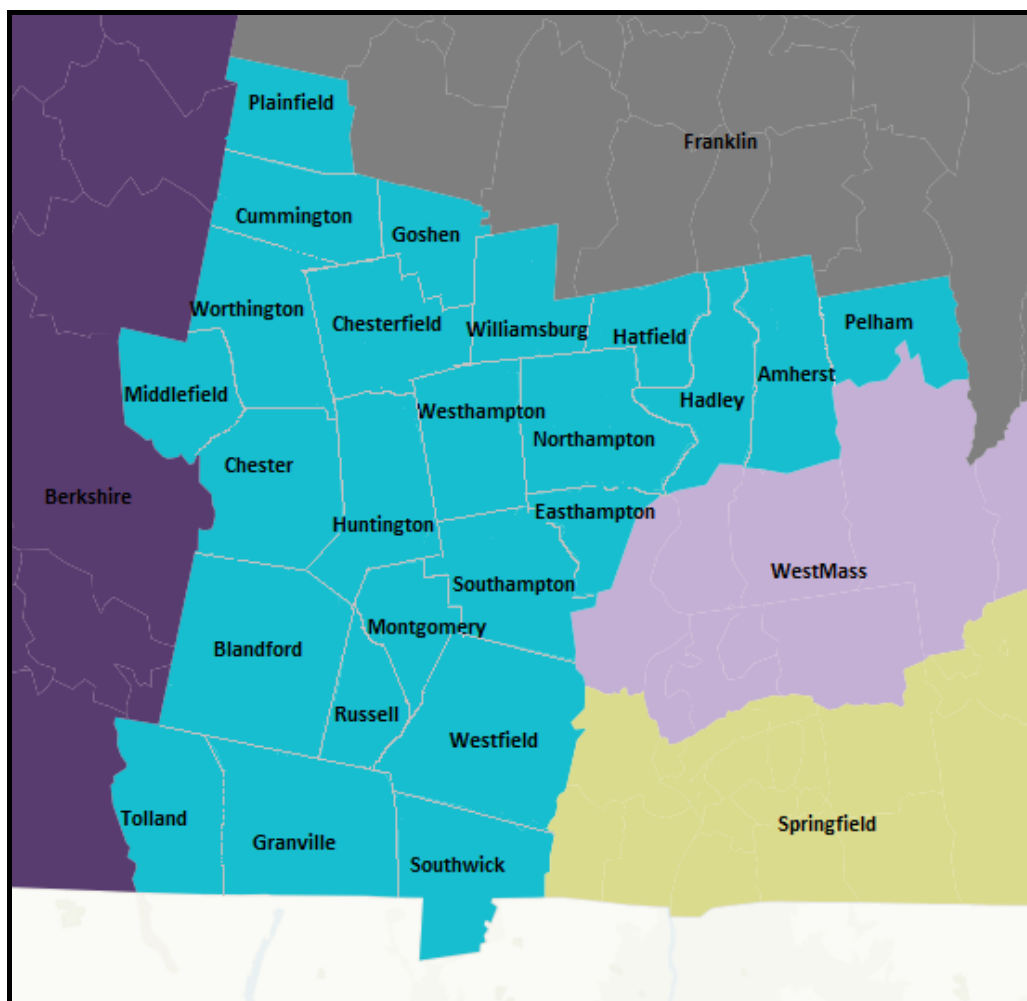




**Highland Valley Elder Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.highlandvalley.org](http://www.highlandvalley.org)

**320 Riverside Drive, Suite B**  
**Florence, MA 01062**

**413-586-2000**  
**FAX: 413-584-7076**  
**TDD: 413-585-8160**





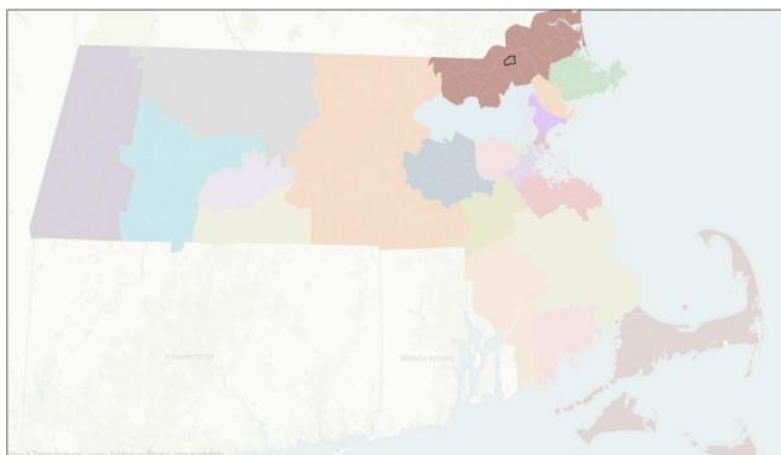
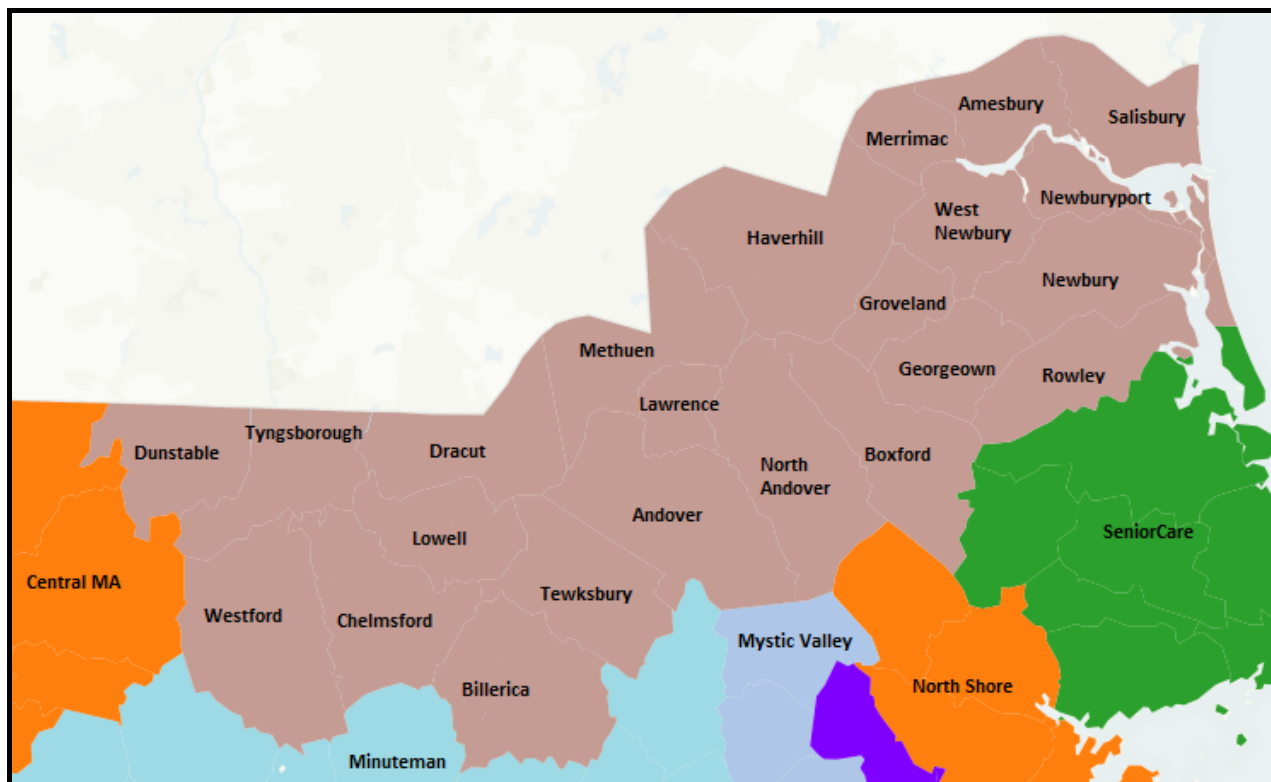


**Elder Services of the Merrimack Valley, Inc.**  
**Area Agency on Aging/Aging Services Access Point**

[www.esmv.org](http://www.esmv.org)

**360 Merrimack Street, Bldg #5**  
**Lawrence, MA 01843**

**800-892-0890**  
**FAX: 978-687-1067**  
**TDD: 800-924-4222**

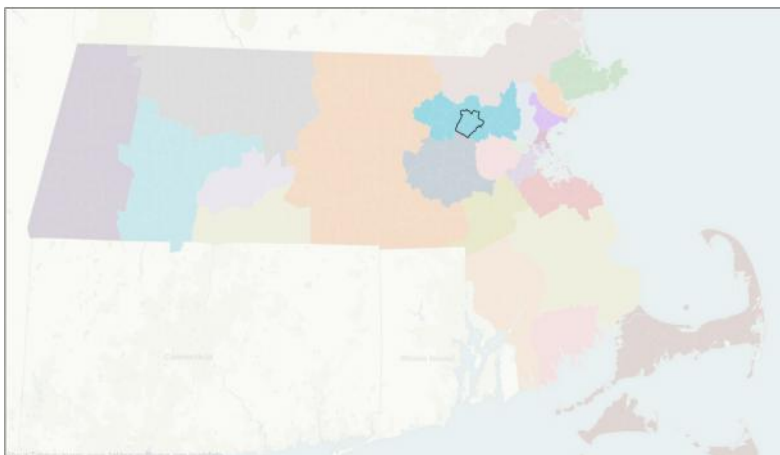
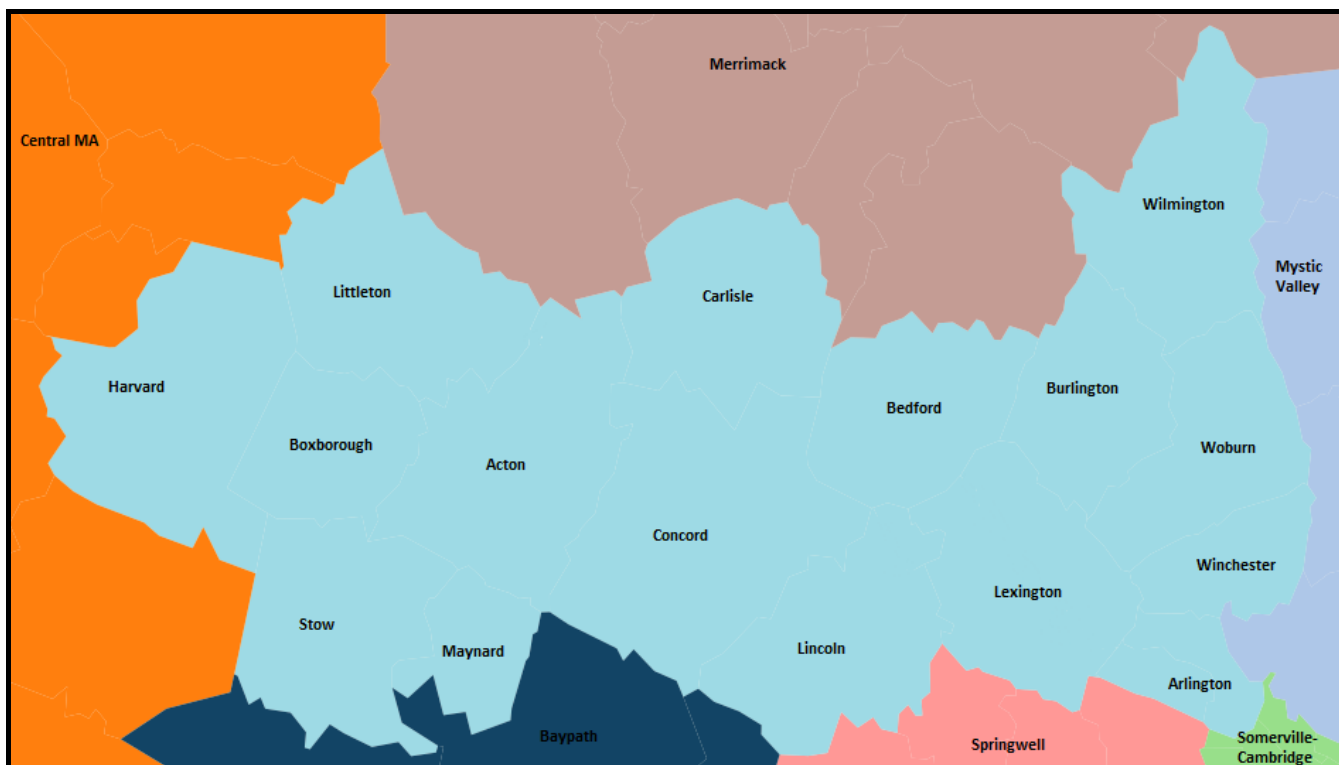




**Minuteman Senior Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.minutemansenior.org](http://www.minutemansenior.org)

**26 Crosby Drive  
Bedford, MA 01730**

**781-272-7177  
FAX: 781-229-6190  
TDD: 781-275-1285**

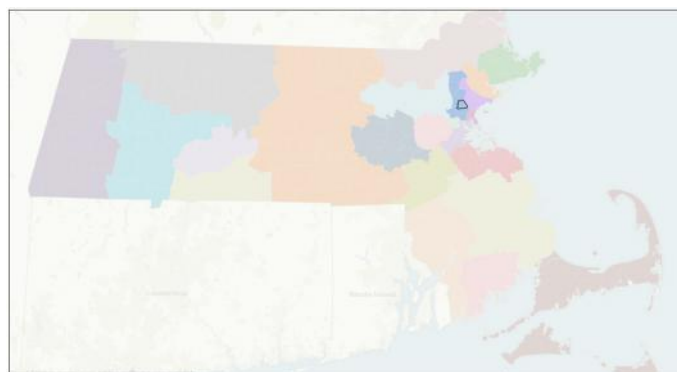
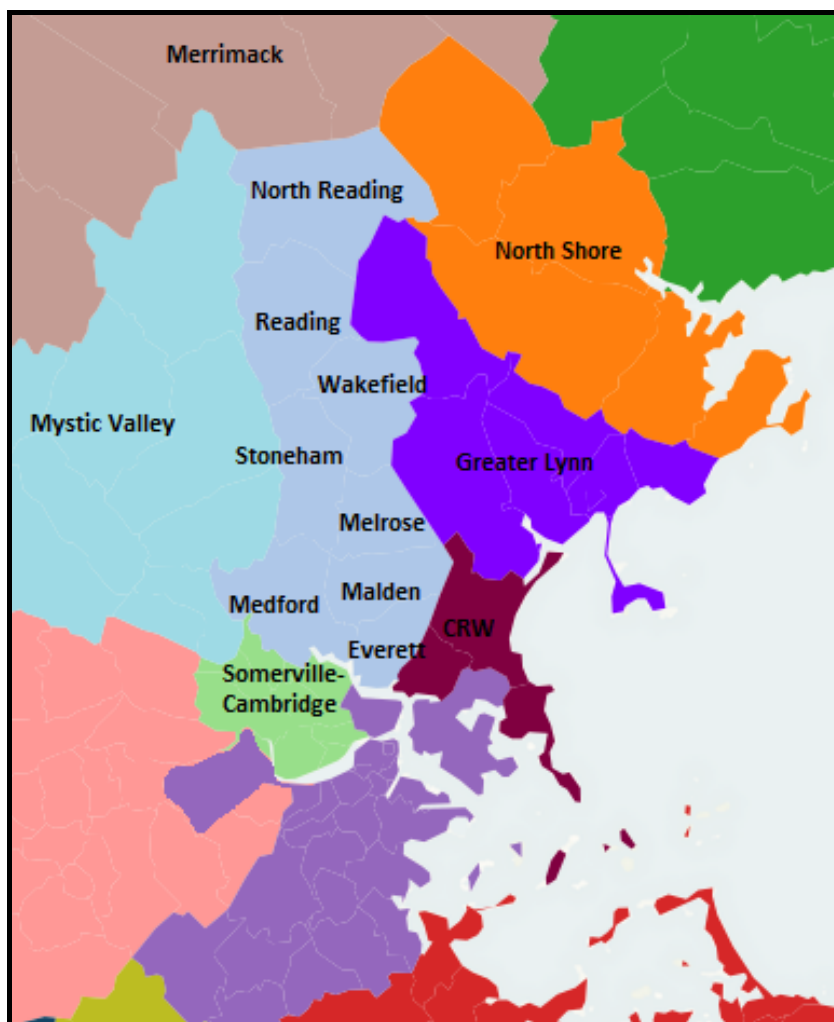




**Mystic Valley Elder Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.mves.org](http://www.mves.org)

**19 Riverview Business Park**  
**300 Commercial Street**  
**Malden, MA 02148**

**781-324-7705**  
**FAX: 781-324-1369**  
**TDD: 781-321-8880**

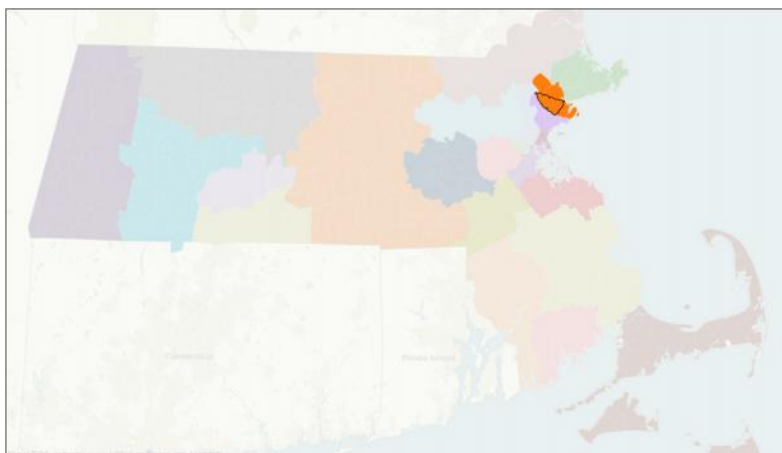




**North Shore Elder Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.nselder.org](http://www.nselder.org)

**152 Sylvan Street  
Danvers, MA 01923**

**978-750-4540/744-4184  
FAX: 978-750-8053  
TDD: 978-750-4540/241**

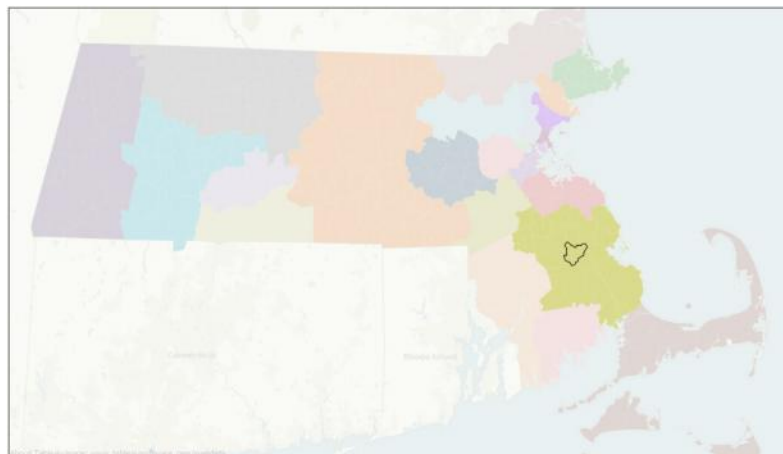
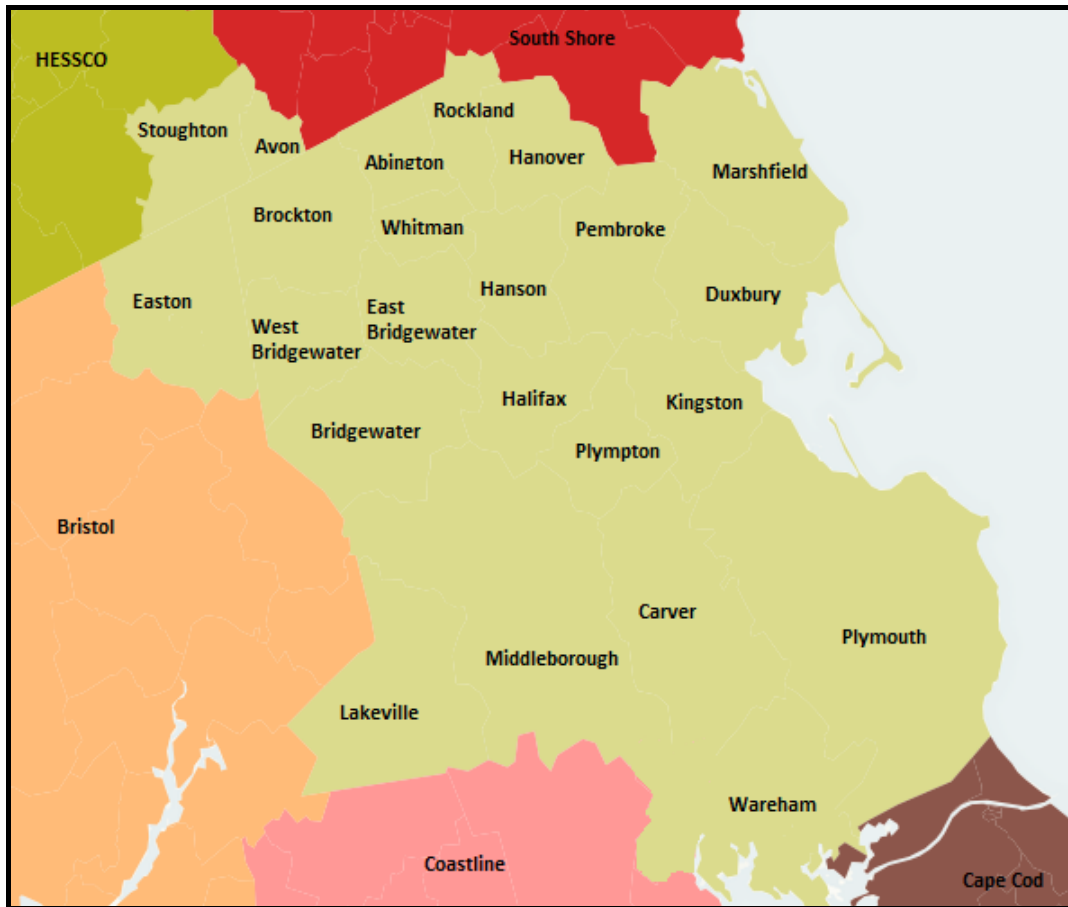




**Old Colony Planning Council**  
**Area Agency on Aging**  
[www.ocpcrpa.org](http://www.ocpcrpa.org)

**70 School Street**  
**Brockton, MA 02301**

**508-583-1833**  
**FAX: 508-559-8768**  
**TTY: 508-583-1833**

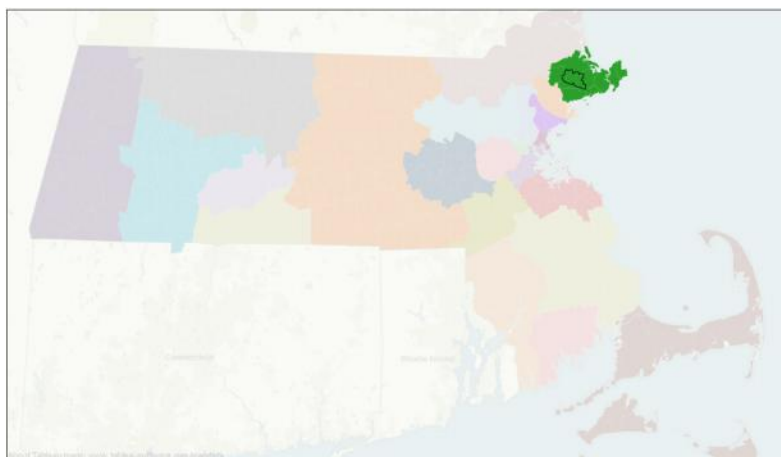
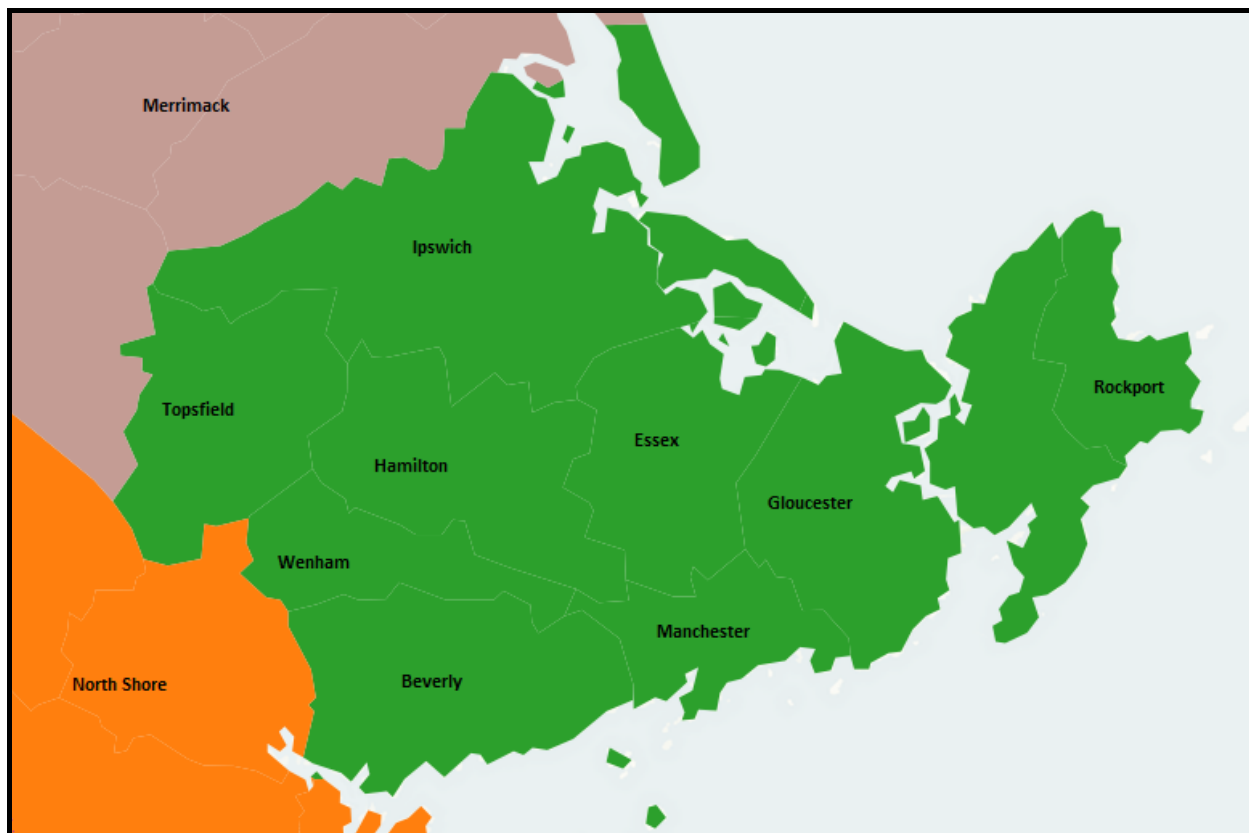




**SeniorCare, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.seniorcareinc.org](http://www.seniorcareinc.org)

**49 Blackburn Center**  
**Gloucester, MA 01930**  
**978-281-1750 or 866-927-1050**  
**FAX: 978-281-1753**

**100 Cummings Center, Suite 106-H**  
**Beverly, MA 01915**  
**TDD: 978-282-1836**  
**FAX: 978-969-0358**

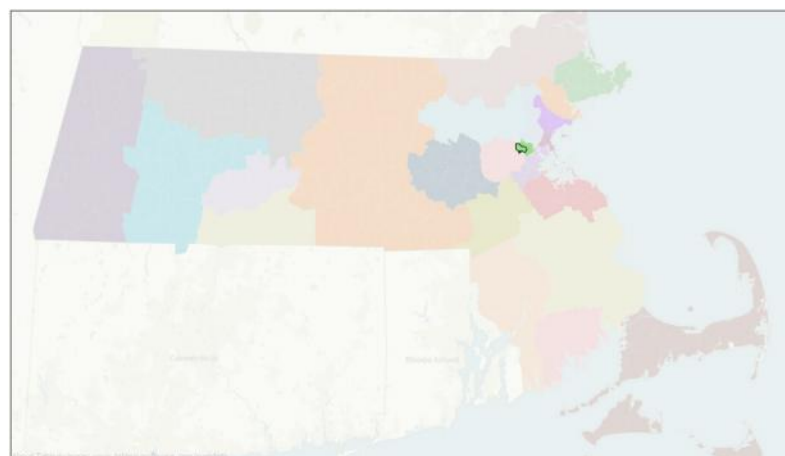
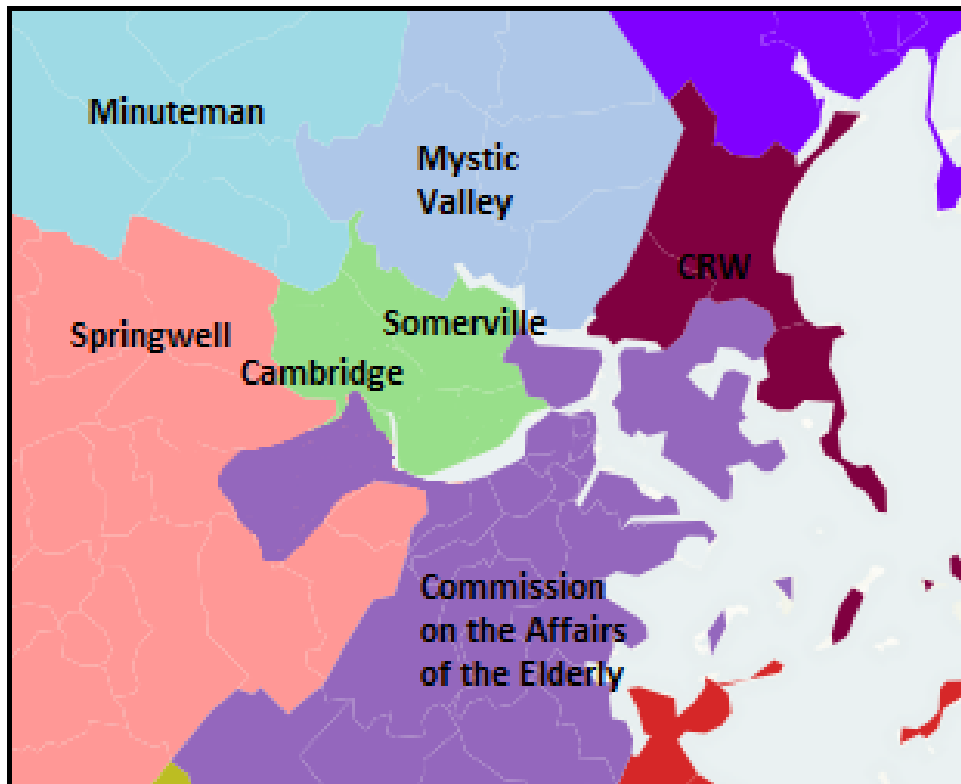




**Somerville/Cambridge Elder Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.eldercare.org](http://www.eldercare.org)

**61 Medford Street  
Somerville, MA 02143-3429**

**617-628-2601  
FAX: 617-628-1085  
TDD: 617-628-1705**



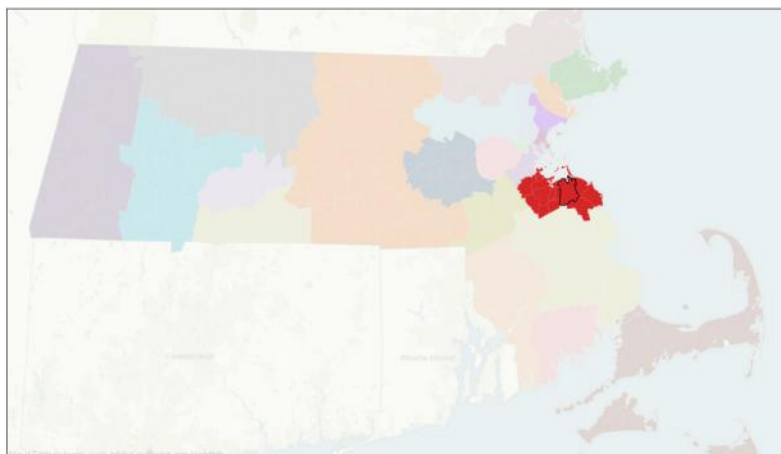
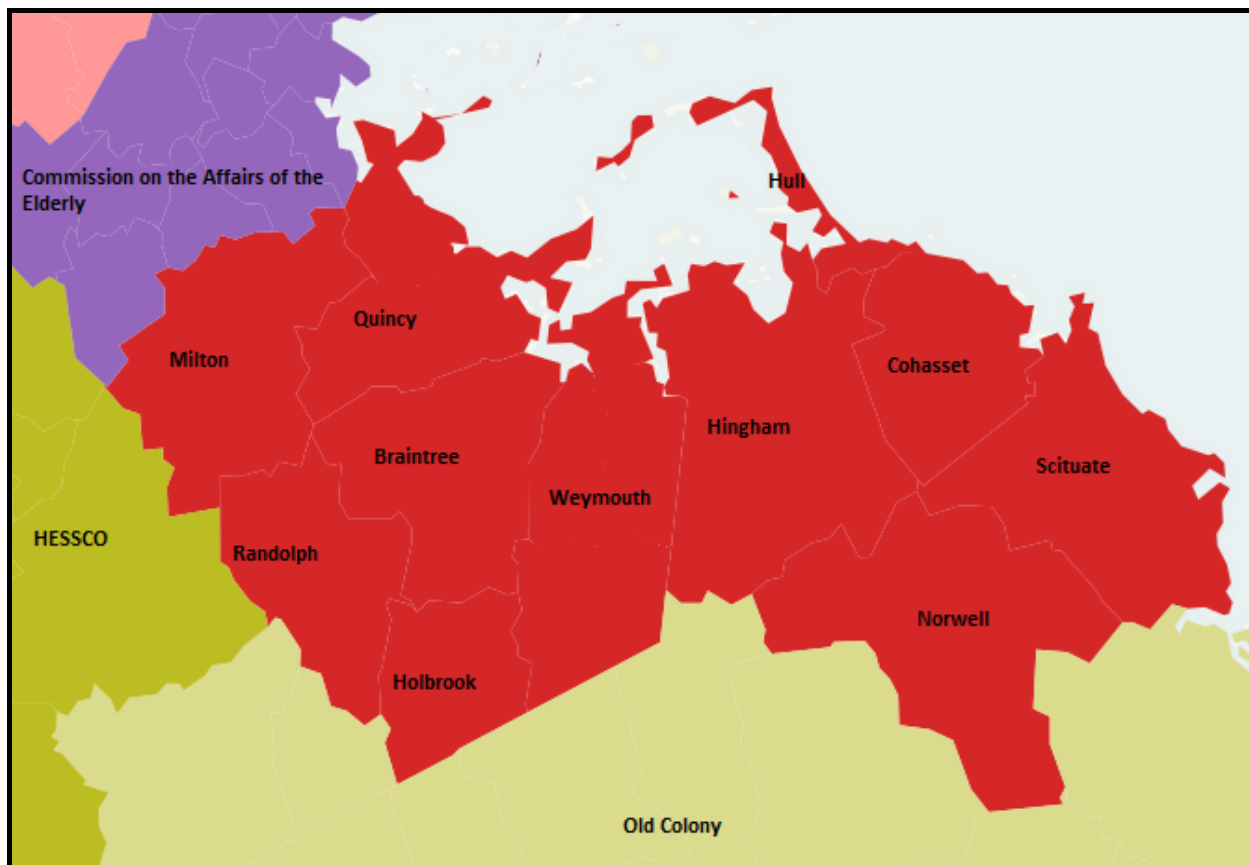




**South Shore Elder Services, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.sselder.org](http://www.sselder.org)

**1515 Washington Street**  
**Braintree, MA 02184-7546**

**781-848-3910**  
**FAX: 781-843-8279**  
**TDD: 781-356-1992**

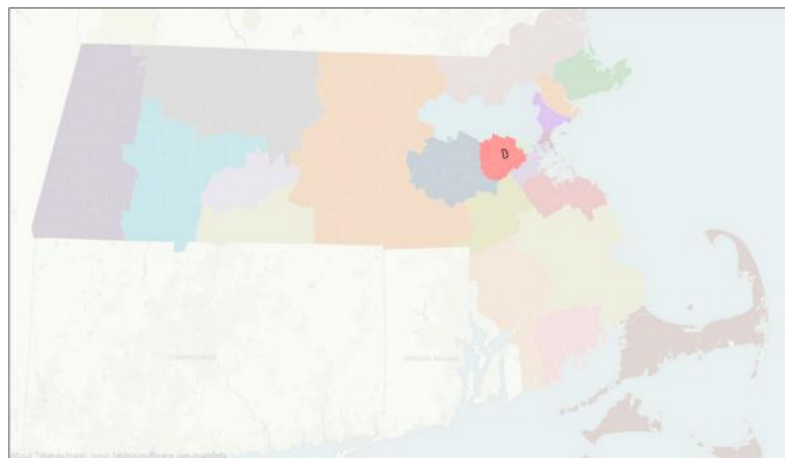
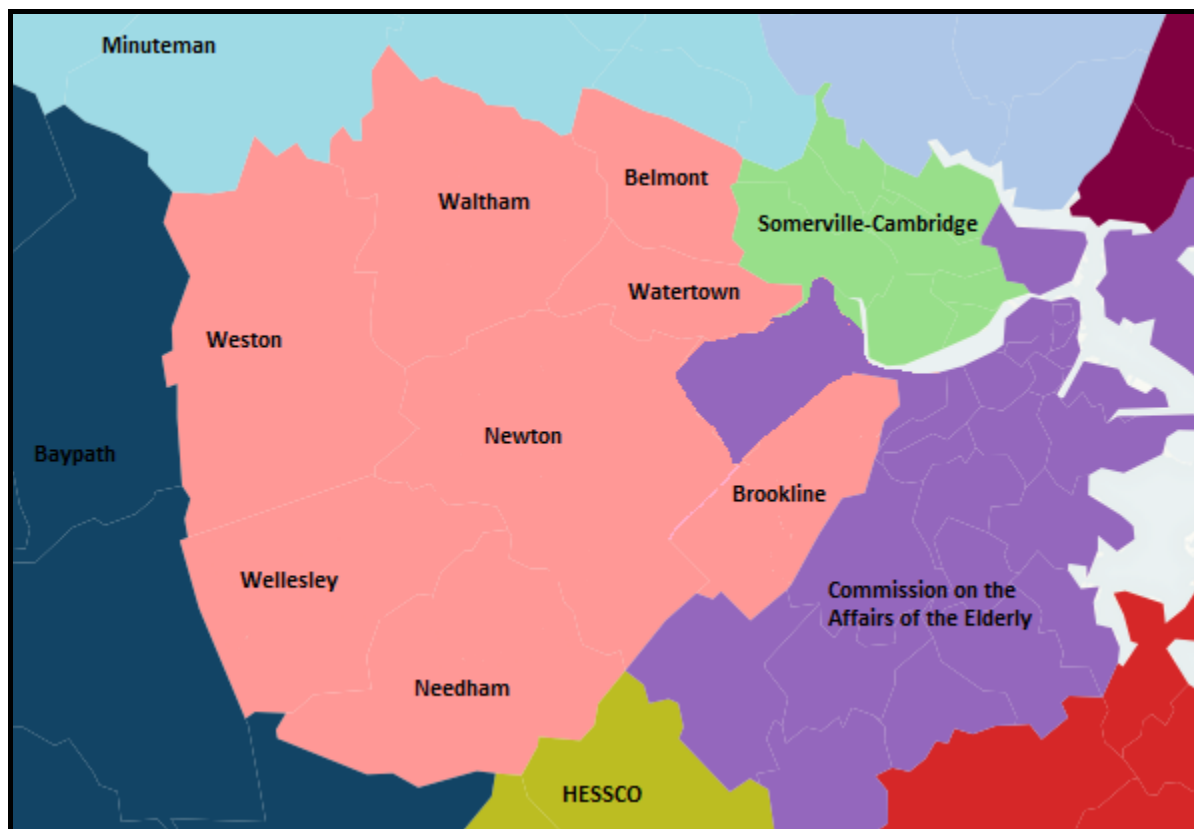




**Springwell, Inc.**  
**Area Aging on Aging/Aging Services Access Point**  
[www.springwell.com](http://www.springwell.com)

**307 Waverley Oaks Road, Suite 205**  
**Waltham, MA 02452**

**617-926-4100**  
**FAX: 617-926-9897**  
**TTY: 617-923-1562**

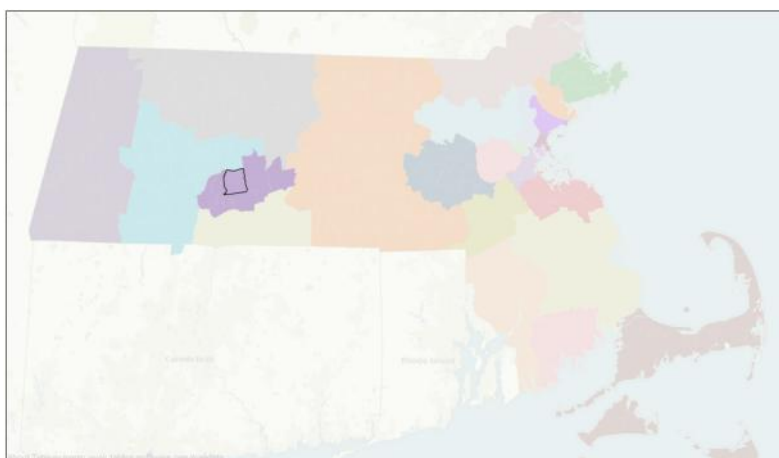
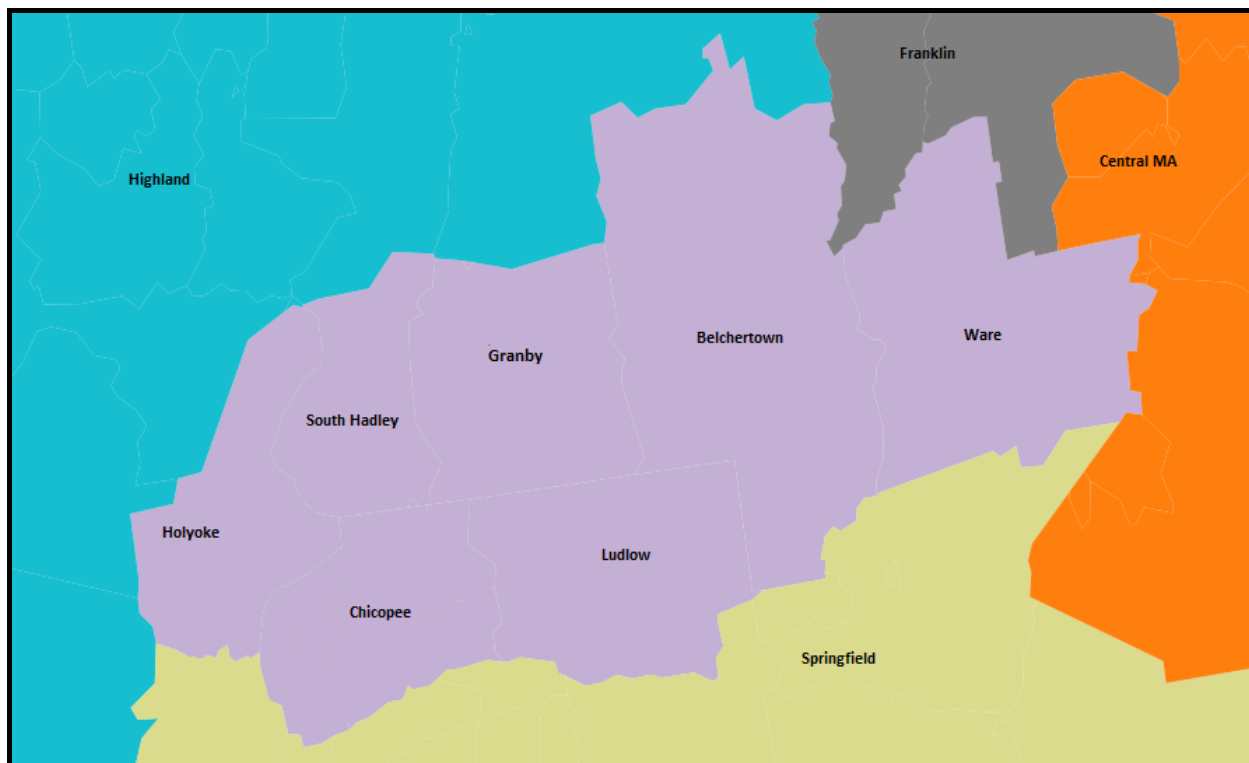




**WestMass ElderCare, Inc.**  
**Area Agency on Aging/Aging Services Access Point**  
[www.wmeldercare.org](http://www.wmeldercare.org)

**Four Valley Mill Road**  
**Holyoke, MA 01040**

**413-538-9020**  
**FAX: 413-538-6258**  
**TDD: 800-875-0287**





## **Aging Services Access Points**

Listed below are the seven Aging Services Access Points (ASAPs) that do not share physical location with one of the state's twenty-three Area Agencies on Aging. They nonetheless cooperate with that Area Agency on Aging that is geographically proximate. The ASAPs are:

ETHOS  
555 Amory Street  
Jamaica Plain, MA 02130  
(617) 522-6700  
[www.elderinfo.org](http://www.elderinfo.org)

Central Boston Elder Services  
2315 Washington Street  
Roxbury, MA 02119  
(617) 277-7416  
[www.elderinfo.org](http://www.elderinfo.org)

Boston Senior Home Care  
Lincoln Plaza Suite 501  
89 South Street  
Boston, MA 02111  
(617) 292-6211  
[www.elderinfo.org](http://www.elderinfo.org)

Tri-Valley Elder Services, Inc.  
10 Mill Street  
Dudley, MA 01571  
(508) 949-6640  
[www.trivalleyinc.org](http://www.trivalleyinc.org)

Montachusett Home Care Corp.  
680 Mechanic Street—Suite #120  
Leominster, MA 01420  
(978) 537-7411  
[www.montachusetthomecare.com](http://www.montachusetthomecare.com)

Elder Services of Worcester Area, Inc.  
67 Millbrook Street, Suite 100  
Worcester, MA 01606  
(508) 756-1545  
[www.eswa.org](http://www.eswa.org)

Old Colony Elderly Services, Inc.  
144 Main Street  
Brockton, MA 02301  
(508) 584-1561  
[www.oldcolonyelderservices.org](http://www.oldcolonyelderservices.org)

ETHOS, Central Boston Elder Services and Boston Senior Home Care work closely with the City of Boston Commission on Affairs of the Elderly AAA. The three ASAPs in central Massachusetts, Tri-Valley Elder Services, Montachusett Home Care Corp., and Elder Services of Worcester Area, receive support and cooperation from Central Mass Area Agency on Aging in West Boylston. While the final ASAP, Old Colony Elderly Services, collaborates with Old Colony Planning Council Area Agency on Aging, with both located in Brockton.